From:	Rixen,Steven J
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	VHA Inc."s Comments on Form 990 Revision
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Attachments:	990 comments 9-12-07.pdf

Please find attached VHA Inc.'s comments on the proposed revisions to Form 990.

September 12, 2007

BY ELECTRONIC FILING

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue N.W.
Washington, D.C. 20224

RE: COMMENTS ON DRAFT FORM 990, including SCHEDULE H

VHA Inc. (VHA) appreciates the opportunity to submit comments on the proposed new Schedule H for hospitals and other selected portions of the redesigned Form 990 (Draft Form 990) and its various accompanying schedules. VHA also appreciates the major task undertaken by the Internal Revenue Service (IRS) in revising and redesigning these forms, as well as the efforts that it has already made to educate and respond to stakeholders in the process of soliciting comments. VHA applauds the IRS for utilizing the CHA/VHA community benefit reporting model as the basis for the proposed new Schedule H.

About VHA

Founded in 1977 as Voluntary Hospitals of America, VHA is dedicated to the success of nonprofit, community-based health care. For the past fifteen years, VHA has worked in close cooperation with the Catholic Health Association of the United States (CHA) on the development of user-friendly community benefit planning and reporting materials. In June of this year, VHA sent updated community benefit kits to its regional offices for distribution to more than 1,000 hospital and health care executives. VHA strongly and proactively supports the adoption of comprehensive and consistent reporting of community benefit activities (including charity care) by nonprofit hospitals.

Based in Irving, Texas, VHA is a national health care provider alliance of more than 2,200 nonprofit health care organizations. VHA helps its members deliver safe, effective and cost-efficient health care through both national and local support. VHA has 17 regional offices covering 47 states as well as offices in Washington, D.C.

Overview of Comments

In releasing the Draft Form 990 and its schedules, the IRS stated that the redesign project was based on three guiding principles:

- Enhancing transparency
- Promoting compliance, and
- Minimizing the burden on filing organizations.[1]

In VHA's view, the re-designed Draft Form 990 meets only one of these three enunciated principles or goals. It will clearly involve a quantum leap in **transparency**, but only at the cost of increasing the already substantial **burdens** imposed on the filing tax-exempt organizations, particularly community

[1] IR-2007-117, June 14, 2007 (available at http://www.irs.gov/newsroom/article/0,,id=171329,00.html).

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hospitals. VHA also questions whether the new Form will effectively promote taxpayer **compliance** and tax administration.

In VHA's view, a substantial part of the anticipated burden could be alleviated if the Form 990's questions were limited to items that are clearly connected to **current law standards**--against which compliance or noncompliance can and should be measured. Unfortunately, the Draft Form 990, particularly the Form's new Schedule H (Hospitals), contains many items that do not correlate to enacted legislative standards or duly promulgated administrative rules.

VHA's comments include a special focus on the new Schedule H, followed by a review of various items contained in the core Form and the other Schedules that we believe may be of particular concern to and/or extremely burdensome for not-for-profit community hospitals.

I. COMMENTS ON SCHEDULE H

Legal Standards Governing Tax-Exempt Hospitals

From the inception of the federal income tax, a large majority of hospitals have qualified for exemption from federal income taxation. While healthcare is not specifically mentioned in Section 501(c)(3) of the Internal Revenue Code, hospitals have always fit squarely under the category of "charitable" organizations that qualified for exemption, along with universities, churches and other nonprofit organizations that benefit the community in various important ways.

For over fifty years, the IRS has employed special rules for judging whether a hospital merits tax exemption under Section 501(c)(3) and other tax code provisions relating to charitable organizations. IRS published the first formulation of the rules in 1956. Revenue Ruling 56-185 contained a four-part test:

(1) The hospital was organized on a nonprofit basis to care for the sick,
(2) The hospital, to the extent of its financial ability, served those unable to pay for services, not just paying customers,
(3) The hospital maintained an open medical staff and did not restrict use of its facilities to a particular group of physicians,
(4) Like other 501(c)(3) organizations, its earnings did not inure, directly or indirectly, to any private shareholder or individual.

In examining hospitals, IRS placed the main emphasis on the second prong of the test--serving patients unable to pay for health care services to the extent of the hospital's financial ability; thus, the test contained in Revenue Ruling 56-185 came to be known as the "financial ability" standard.

Three years later, the IRS acknowledged for the first time that charity was not confined to relief for the poor. In 1959 regulations defining "charitable" purposes, the IRS announced that the term "charitable" was used in its generally accepted legal sense. There was no direct mention of health in the1959 rules. But the regulations laid the theoretical groundwork for issuance of Revenue Ruling 69-545, discussed below.

The "financial ability" standard proved difficult to enforce. It was far from a model of clarity. Some IRS examiners, apparently uncomfortable with the ambiguities of how to gauge the financial ability of hospitals, reportedly informed hospitals that if they wanted to retain tax exemption, they had to earmark at least five percent of patient revenues for charity care.[2] However, neither Congress nor the IRS chose to adopt a five percent test--or any other quantitative test of charity care or community benefit.

[2] See generally *The IRS and Community Benefit*, Colloquium Report On Legal Issues Related To Tax Exemption And Community Benefit, p. 4 (National Health Lawyers Association 1996).

Revenue Ruling 69-545 moved beyond the financial ability standard that required hospitals to provide as much free care as they could afford. Community benefit, not charity care, became the touchstone for health care providers' exemptions.

The 1969 IRS ruling stated that the "promotion of health . . . is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as [the] indigent." A hospital could qualify for exemption under the new "community benefit" ruling by satisfying the following criteria:

- Operating a full-time emergency room open to all, regardless of the patients' ability to pay;
- Providing hospital care for everyone able to pay, whether they relied on their personal resources, private insurance, or financial assistance from public programs such as Medicare or Medicaid;
- Demonstrating that it is operated to serve public rather than private interests by
  --having a board of directors drawn from the community, and an open medical staff, and
  --applying any surplus revenues to improving facilities, equipment, patient care and medical education and research.

In 1983, in Revenue Ruling 83-157, the IRS allowed that under certain circumstances, even hospitals without emergency rooms could qualify for exemption under the community benefit standard, such as when a state health planning agency determined that opening yet another emergency department in a community would be a waste of resources. This ruling also recognized that specialized facilities such as eye and cancer hospitals seldom treated patients needing emergency room care. (Subsequently, the IRS has emphasized that these specialized hospitals without emergency rooms are the exception, not the rule, and that most acute care hospitals must run a 24-hour emergency room it they want to remain exempt.)

IRS VIEW OF THE SUBSTANTIVE LAW

In the Instructions to Schedule H, the IRS states the proposed schedule "is designed to combat the lack of transparency" surrounding the activities of tax-exempt organizations that provide hospital or medical care. The IRS also asserts that in the Schedule H Instructions that "[i]n drafting [Schedule H], the Service tried to quantify, in an objective manner, the community benefit standard applicable to tax-exempt hospitals." Thus, the IRS acknowledges that the community benefit standard, which requires the promotion of health in accordance with community needs, remains the legal basis for hospital tax exemption. However, this assertion is not consistent with current federal tax law, which as noted above does not set forth a quantifiable community benefit standard for hospital tax exemption. The assertion is also inconsistent with the prior public remarks of the IRS Commissioner, who stated in recent Congressional testimony that the IRS is "comfortable" with the current legal standard because it enables the IRS to inquire about charity care, but also take into account other charitable activities of the hospital, such as medical education and research.[3]

GENERAL COMMENTS ON COMMUNITY BENEFIT STANDARD

In order to properly re-align the new Schedule H with the law's current hospital exemption standard, the IRS should focus the opening section of the Schedule H on determining whether the hospital is meeting

[3] *The Tax-Exempt Hospital Sector, Hearing on Tax-Exempt Hospitals Before the House Comm. On Ways and Means*, 2005 Leg. (May 26, 2005) (statement of IRS Commissioner Mark Everson). At this hearing, Commissioner Everson expressed concerns about the possible adverse unintended consequences that could result from establishing a quantitative or "bright-line" test; the Commissioner also stated that hospitals are in the best position to know what charity care policy best suits the community they serve and that implementing a quantifiable standard would have a negative impact on communities at variance with that standard.

the multi-factor test set forth in Revenue Ruling 69-545--e.g., does the hospital have an open emergency room, does it have an open medical staff, does it treat patients whose care is funded by government programs, such as Medicaid and Medicare, does it have a community board, and so forth. VHA urges you to redraft the Schedule H along the lines of the proposed Schedule H submitted to you on August 6, 2007 on behalf of the various hospital groups (including VHA, CHA, and the American Hospital Association) that helped draft the alternative schedule. In VHA's view, the re-drafted Schedule H should contain questions referencing each one of the Rev. Rul. 69-545 community benefit factors.

Arguably, to be consistent with the basis on which tax exemption is actually granted to hospitals, the IRS should not include in Schedule H the numerically-oriented Community Benefit Report chart. However, VHA acknowledges that consistent and more readily comparable reporting on Community Benefit expenditures and activities does have some value. Thus, it has been urging member hospitals to "tell their story" through both objective metrics and narrative descriptions. Further, VHA has recommended that member hospitals utilize the Social Accountability budgeting approach to measuring charity care.

Accordingly, if the IRS does include a quantifiable community benefit chart as a mandatory feature of the Form 990, VHA would support its inclusion so long as the following safeguards are put in place.

- First, **IRS auditors reviewing the Form should be instructed that selection of a particular hospital for an IRS audit should <u>not</u> be made on the basis of a hospital's Form 990 "numbers" alone.** Indeed, the numbers should have very little influence over selection of the hospital for examination or any challenge to its tax exemption.

- Second, **Schedule H should be redesigned so that non-quantifiable community benefit factors (i.e., questions specifically related to each of the factors contained in Revenue Ruling 69-545) precede the quantitative community benefit chart.** Rearranging the form in this fashion will allow hospitals an opportunity to present the IRS and the public with the broader picture before any focus on statistics devoid of context. This rearrangement would also further the IRS's objective of increased transparency and provide the IRS with better information.

- Third, the **Community Benefit Report chart should include all facets of the CHA/VHA definition of community benefit, including "community building" expenditures.**

- Fourth, **hospitals should not be frustrated in their attempts to tell their "community benefit" stories by the new electronic filing system's inability to accept attachments.**

These and other specific comments are discussed below.

COMMENTS ON SPECIFIC PARTS OF SCHEDULE H

<u>Schedule H, Part I (Omission of Community Building)</u>

The Instructions to the Schedule H state, [F]or the purposes of advancing the discussion in this [community benefit] area, the Service chose to utilize the Catholic Health Association's (CHA) community benefit reporting model." However, the Part I of the Schedule H fails to request any data on "community building" activities--a category that is specifically included in the CHA/VHA community benefit reporting model.

IRS staff members have indicated in meetings and phone conference calls with nonprofit hospital representatives that they intentionally omitted any reference to the category of "community building" activities because they felt that such activities would be hard to quantify and that some hospitals might use community building expenditures to inflate their over-all community benefit numbers. IRS has also expressed the view that community building is not appropriate to include in a hospital community benefit measuring tool insofar as it may not always involve the <u>direct</u> provision of <u>health</u> care--even though it generally involves activities that promote community well-being and are undeniably charitable in nature

(e.g., providing safe and decent housing to the poor in a hospital's service area, working proactively to prevent and address spousal abuse and domestic violence).

VHA believes that the IRS should consistently utilize the CHA/VHA model, and not pick and choose from among its elements. Moreover, VHA does not believe hospitals will use "community building" expenditures to inflate their overall community benefit numbers since such numbers--if they are included at all--will be reflected in a separate column on the quantitative Community Benefit Report chart and will be easily distinguishable from other components of community benefit. At the very least, hospitals should be given an opportunity to describe their community-building activities on the Form 990's new Schedule H.

Schedule H, Part I, Lines 1-4 (Exclusion of Medicare Shortfalls)

The Charity Care portion of the Schedule H "Community Benefit Report" allows only three components to count for charity care-- charity care at cost, unreimbursed Medicaid (i.e., net Medicaid shortfalls), and unreimbursed costs from "other government programs" (excluding Medicaid and Medicare).

VHA generally agrees that Medicare shortfalls should not be counted as "charity care" since many hospitals compete for Medicare patients. However, like many hospital organizations, VHA believes that Medicare does not consistently compensate hospitals for the actual cost of providing services and that Medicare shortfalls are often borne disproportionately by hospitals serving a large number of vulnerable patients needing extensive and treatment. Thus, VHA supports having Medicare shortfalls reflected somewhere on the new Schedule H or Form 990 as they are clearly relevant to both the hospital's community benefit and to the total revenue picture of a hospital.

Schedule H, Part I, Line 13 (Charity Care Budgeting)

The new Schedule H inquires as to whether the hospital "imposes aggregate budget caps or other limitations that may result in persons otherwise eligible under the charity care policy to not receive free or discounted care."

The Draft Schedule H asks whether the organization has a charity care policy and, if so, to describe it including in the description whether the organization ". . . imposes aggregate budget caps or other limitations that may result in persons otherwise eligible under the charity care policy to not receive free or discounted care." VHA objects to this formulation because it is not rooted in any specific requirement under current federal tax law. Under current law, hospitals are not required to provide a specific amount of charity care or to treat indigent patients without charges to the extent of their financial ability. As noted above, the IRS replaced the "financial ability" standard in 1969.

Furthermore, the inquiry about "aggregate budget caps" implies that realistic budgeting for charity care is undesirable. Nothing could be further from the truth: Nonprofit hospitals must be both thoughtful and intentional stewards of their resources, including those they devote to charity care, and particularly in times of financial exigency. While VHA agrees that charity care is an important component of community benefit, hospitals must be allowed to budget for charity care and be given the latitude to adhere to their budgets--or at least some community health care institutions will suffer adverse financial ramifications, thus harming their ability to serve their communities, or in some cases even jeopardizing their continued existence. As a practical matter, the CHA/VHA Social Accountability community benefit reporting approach encourages hospitals to budget for community benefit programs generally, and for charity care in particular.

Schedule H, Part II, Lines 1-6 (Billing and Collection Information)

Part II of the new Schedule H requests detailed financial information on gross charges, discounts, net revenues expected and fees collected with respect to five categories of patients--Medicare patients, Medicaid patients, patients whose care is funded by other government programs, insured patients and

uninsured patients. It also asks for explanations of how the organization calculates bad debt expense, whether it has a written debt collection policy and (if so) to provide a description of the policy.

There is no statutory standard or any clear guidance from IRS on billing policies that nonprofit hospitals should adopt. IRS is unlikely to provide any such guidance unless Congress enacts legislation that places limitations on nonprofit hospital charges. Although Senate minority staff have produced a discussion draft proposing specific limitations on what nonprofit hospitals could charge "medically indigent" and/or uninsured patients, Congress is not likely to take any action on such proposals in the foreseeable future. VHA and other hospital groups strongly object to the imposition of price controls on nonprofit hospital services as a solution to the widespread and systemic problem of inadequate health coverage.

Given that there are no current statutory or IRS requirements that control the prices nonprofit hospitals may charge, it would be completely inappropriate for the IRS to include in the Draft Form 990 a section mandating the public disclosure of information relating to hospital billing charges. It would also be extremely burdensome for hospitals to produce such information with respect to the five different patient categories noted above. Moreover, some of the information solicited about billing involves confidential pricing information, the release of which would financially harm hospitals in their negotiations with payors. There is also no federal tax law standard for how a tax-exempt hospital should administer its debt collection policy. VHA believes that all hospitals should have a written debt collection policy that takes into account the financial ability of the patient to pay for services rendered--whether or not the patient initially qualified for charity care. VHA also believes that all hospital collections departments should adhere to the provisions of the Federal Fair Debt Collections Practices Act. However, VHA is concerned that the IRS' compliance focus on this aspect of hospital administration may be premature in the absence of any articulated federal legislative or administrative standards which tax-exempt hospitals must follow.

In sum, the burden and resulting damage to hospitals imposed by Part II of the new Schedule H is unsupportable in the absence any legitimate tax compliance purpose to be served. The IRS' proposed inclusion of the quantitative information on billing and collection does not relate to any standard that either Congress or the IRS has adopted to measure hospital compliance under section 501(c)(3) or other relevant Code provisions. VHA does not believe that hospital tax information returns should be used to collect information in support of proposed legislative reforms. Accordingly, VHA joins with many others in the tax-exempt hospital community in urging the IRS to delete Section II (Billing and Collection) of the new Schedule H in its entirety.

Schedule H, Part III, Lines 1-10 (Management Companies and Joint Ventures)

Part III of the Draft Schedule H requests detailed ownership and other information on management companies and joint ventures of which the hospital is a partner or shareholder and which are owned (in the aggregate at least 5 percent) by current or former officers, trustees, key employees or hospital staff physicians. Specifically, for each such entity, Part III of the Draft Schedule requires the hospital to list the name of the management company or joint venture, a description of its primary activity, the hospital's ownership share, the aggregate ownership or profit share of officers, directors, trustees or key employees, and the aggregate ownership share of any physician owners.

This information will be very burdensome, if not impossible, to obtain. The joint venture information is also duplicative in light of the detailed information on joint ventures required to be disclosed by Schedule R and the Draft Form 990.[4] The information will be particularly difficult to obtain with respect to companies where the hospital has less than a controlling share in the ownership.

[4] The portion of the Draft Form 990 that relates to joint ventures and management companies is Part VII, Lines 8a, 8b, and 8c. Line 8a asks if the filing organization conducted all or a substantial part of its exempt activities through or using a partnership, LLC or corporation. If the answer is yes (and the organization's ownership is 50 percent or less), line 8b requires the filing organization to identify the partnership or LLC by name, describe its primary activity, specify the organization's ownership percentage and specify the type of entity. If the filing organization's ownership of a partnership, LLC, or

Further, it is not clear what tax compliance purpose the information is intended to serve, and why hospitals are being singled out. VHA is not aware of any public IRS guidance relating only to hospital joint ventures--other than that relating to so-called "whole-hospital joint ventures." If there are no special rules for hospital joint ventures, it seems unfair and unwarranted to impose special reporting requirements on hospitals.

Thus, **VHA would urge the IRS to delete this section**. If included at all, it should be limited to whole hospital joint ventures or to those hospital management or joint venture companies in which the hospital has a significant share of the ownership (i.e., at least 30 percent) and/or the aggregate share of the related individuals also exceeds a certain threshold (i.e., over 30 percent).

Inability to Attach Documents to the Schedule H/Form 990

VHA understands that IRS intends to not permit the attachment of documents or backup information to the new Form 990 or the Schedule H. The IRS's unwillingness to accommodate attachments is related to the technical requirements of electronic filing within the IRS computer system.

VHA is concerned with the minimal amount of space that the new Form 990 allots for charity care policy and other descriptions. A well articulated statement may require much more space and/or necessitate attachments. Hospitals with a strong program and record will want to tell their story. VHA has suggested that the IRS allow hospitals to provide information via live links and/or PDF attachments. Such live links would direct the reviewer to specific section of the hospital's website.

While we understand the IRS may have concerns (i.e., a link may become outdated, references to attachments may be non-responsive), VHA believes that the IRS and hospitals could make this work. If live links and/or PDF attachments are allowed, VHA would anticipate that the Form 990 instructions would remind filers to appropriately summarize data and answer questions concisely (and not to use such links or attachments as a substitute for answering a question within the four corners of the Form).

II. COMMENTS ON THE DRAFT FORM 990

Part I, Lines 6, 7, and 8 (Compensation Information and Ratios)

Part I, Lines 6, 7, and 8 require organizations to (1) list the number of individuals receiving compensation in excess of $100,000, (2) enter the highest compensation amount reported for any one individual for the organization and all related organizations, and (3) calculate what percentage of program service expense is comprised of compensation paid by the organization's officers, directors and key employees.

It is not clear what, if any, tax compliance goal is served by requiring this information to be listed on the first page of the redesigned Form 990. In general, because hospitals have relatively large proportions of program service expenses, they should have fairly good ratios. However, for many small nonprofit organizations, the resulting ratio will reflect a much higher proportion of compensation to program service expenses. Should this be cause for a negative tax compliance conclusion? VHA does not think so. In addition, VHA questions the relevance and appropriateness of listing the highest compensation amount for any one individual or the number of highly compensated individuals (defined as greater than $100,000) that an organization has on its payroll as employees or independent contractors. Even if the rationale for this proposal is to achieve "greater transparency," any benefit associated with that transparency may be illusory, given that hospitals tend to employ and/or contract with a relatively high number of professionals—such as physicians, advanced nurse practitioners, physician assistants, in-house attorneys, accountants and others—whose compensation may equal or exceed $100,000 per year.

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corporation is more than 50 percent, the organization is required to file Schedule R which asks a number of other questions.

Part II, Section B, Line 3 (Section 4958 Rebuttable Presumption Procedures)

Part II, Line 3 asks "[F]or CEO, Executive Director, Treasurer, and CFO . . . did the process for determining compensation include a review and approval by independent members of the governing body, comparability data, and contemporaneous substantiation of the deliberation and decision."

This question implies that all tax-exempt organizations should avail themselves of the procedures for establishing the rebuttable presumption of reasonableness under Section 4958 of the Internal Revenue Code when determining the compensation of these specific officers. The need for following these procedures should be evaluated by organizations and their counsel on a case-by-case basis. However, by asking the question in the way it is posed, many organizations will feel constrained to undertake these expensive and burdensome reviews for the specified positions.

Part III, Line 2

Part III, line 2 asks whether an organization made any significant changes to organizing or governing documents, and if so, briefly describe these changes.

The redesigned Form 990 needs to provide more space in order to accommodate adequate answers. The two lines provided may not be sufficient to explain significant changes in an organization's governing documents. This is another example of a question that should be accompanied by the option to attach a document via a live link or a PDF attachment.

Part III, Line 3

Part III, line 3 inquires as to how many transactions the organization reviews each year under its conflict of interest policy.

The number of transactions an organization reviews under its conflict of interest policy is not relevant. Instead, the inquiry should be whether any transactions have been reviewed under the organization's conflict of interest policy and the answer should be a simple "Yes or No."

SCHEDULE A (SUPPLEMENTARY INFORMATION FOR ORGANIZATIONS EXEMPT UNDER SECTION 501(C)(3))

Schedule A and the Preamble to the Instructions

Schedule A now focuses exclusively on charitable organization's public charity status, and the Preamble to the Schedule A Instructions states that the IRS is considering using Schedule A to issue definitive rulings of public charity status in lieu of the "Form 8734 process."

This is a positive step toward streamlining the process of determining an organization's public charity status. In addition, this streamlined process should allow hospitals to dispense with Schedule A altogether after obtaining a favorable ruling.

SCHEDULE C (POLITICAL CAMPAIGN AND LOBBYING ACTIVITIES)

Part I-A, Line 1

Part I-A, Line 1 requires organizations to provide a description of "direct and indirect political campaign activities." However, the Schedule C Instructions do not clearly define an "indirect political campaign activity." In addition, the provision requires organizations to disclose the total number of "volunteer" hours spent on campaign activities.

The IRS should address in instructions to the Schedule C the issue of what is a "direct" and an "indirect" political campaign activity. Examples of activities falling within each category should also be included.

Requiring hospitals to disclose the number of volunteer hours spent on campaign activities is burdensome. Presumably, if the political activities are undertaken on a truly volunteer basis, hospital administrators would not be in a position to make such calculations, and thus, would have to rely largely on conjecture. Thus, the information required to be supplied would not likely be accurate. Moreover, any attempt on the part of the hospital to solicit information about volunteer activities could be construed as a violation of individual privacy rights or as an effort by the hospital to make employment-related decisions based on an individual's personal political beliefs and activities.

SCHEDULE D (SUPPLEMENTAL FINANCIAL STATEMENTS)

Part VII

Part VII requires organizations to "[P]rovide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48."

VHA objects to this requirement because it involves the disclosure of specific financial statement financial information out of context. Further, many if not most hospitals provide complete financial statements on their websites or in some other medium readily available to the public.

SCHEDULE F (STATEMENT OF ACTIVITIES OUTSIDE THE U.S.)

Part I, Part II, and Part III

The Draft Form 990/Schedule F replaces a two-part question from the existing Form 990 (Lines 91(b) and (c)) with a three part schedule with multiple questions and multiple subparts. The existing Form 990 asked whether the organization had an interest in or a signature or other authority over a financial account in a foreign country during the calendar year (Yes or No). The second inquiry on the existing Form 990 asked whether the organization maintained an office outside the United States during the calendar year (Yes or No). If either question is answered in the affirmative, the organization is asked to list the name of the foreign country.

The Draft Form 990 (Part VII, Lines 1(a), (b), and (c)) asks whether the organization conducted any of the following outside the United States: (1) grantmaking, fundraising, trade, business, or program service activities; (2) maintain an office, employees or agents, and (3) maintain an interest in, or signature or other authority, over a financial account. If the organization answers yes to any of these three questions, it must complete a Schedule F. Schedule F requests the following information:

- *Activities per Country*
  - *Country*
  - *Number of accounts or offices in the county (Specify number of each per country)*
  - *Number of employees or agents in country*
  - *Activities conducted in country (by type) (i.e., fundraising, program services, grants to recipients located in the country)*
  - *If activity listed is a program service, describe specific service(s) in country*
  - *Total expenditure in country*
- *Describe the organization's procedures for selecting grant recipients located outside the United States and monitoring the use of grant funds*
- *Did the organization make any grants directly or indirectly to finance political or lobbying activity outside the U.S.*

- *Does the organization describe its activities conducted outside the U.S. in any materials or documents made available to the public*
    - *If "Yes," describe how the public has access to the materials*
- *Was any individual or organization that received a grant or assistance related to any person with an interest in the organization, such as a donor, officer, director, trustee, creator, highly compensated employee, or member of the selection committee*
    - *If "Yes," complete the following:*
        - *Name of the person with interest in the organization*
        - *Relationship between person with interest in the organization and recipient*
        - *Amount of grant or type of assistance*
- *If any organization or entity outside the U.S. received more than $5,000, complete the following for each organization*
    - *Name of the organization*
    - *IRS code and EIN (if tax-exempt)*
    - *City (or Region) and Country*
    - *Purpose of grant*
    - *Amount of cash grant*
    - *Manner of cash disbursement*
    - *Amount of non-cash assistance*
    - *Description of non-cash assistance*
    - *Method of valuation (book, FMV, appraisal, other)*
- *If any individual located outside the U.S. received grants or other assistance, complete the following for each individual*
    - *Type(s) of assistance*
    - *City (or Region) and Country*
    - *Number of recipients*
    - *Amount of cash grant*
    - *Manner of cash disbursement*
    - *Amount of non-cash assistance*
    - *Description of non-cash assistance*
    - *Method of valuation (book, FMV, appraisal, other)*

The new Schedule F is significantly more extensive and will be much more burdensome to complete than the corresponding section in the current Form 990. First, the IRS is requesting significantly more information. Next, securing this information may be difficult, expensive, and time consuming. For example, if a clinic outside the United States is given medical equipment, the donor organization will have to spend extra time and money completing an appraisal of donated items. The donor organization may also need to institute an extensive "due diligence" process to track the donee organization's expenditures. For example, Schedule F, Line 3 asks whether any grants were used to "directly or indirectly" finance political or lobbying activity outside the United States. As a practical matter, there may be no way for a donor organization to know if a grant indirectly financed lobbying activity outside the United States.

In VHA's view, hospitals that undertake or assist with international relief efforts conducted by recognized charitable or governmental organizations should be exempted from filling out this Schedule. The kind of international activity that the IRS is concerned about does not include such disaster and/or disease relief efforts.

SCHEDULE G (SUPPLEMENTAL INFORMATION REGARDING FUNDRAISING ACTIVITIES)

Part I, Line 1a

Part I, Line 1a requires organizations to indicate what activities were undertaken to raise funds, including grants from governments or organizations.

VHA objects to this question as it does not appear to be based on tax compliance objectives.

Part II

Part II requires the organization to list the financial information related to any fundraising events the organization hosted during the year.

It is unclear what tax compliance purpose will be served by gathering this information.

It appears that the IRS's primary concern is the cost effectiveness of various types of fundraising programs, particularly "how much of each dollar given by a donor in good faith is actually provided to a charity for charitable work." Such concerns relate primarily to the regulation of charitable solicitations, which is a matter of state law, not federal tax law.

SCHEDULE J (SUPPLEMENTAL COMPENSATION INFORMATION)

Line 1(E)

Line 1(E) requires the organization to list information regarding nontaxable expense reimbursement information.

There is no tax policy or compliance reason to make this information public. By including this amount, it is more likely that certain individuals with taxable compensation below $150,000 will have to be included on this schedule, especially those individuals whose jobs require significant amounts of travel.

SCHEDULE K (SUPPLEMENTAL INFORMATION ON TAX EXEMPT BONDS)

Parts I and II

Parts I and II require very detailed information regarding each outstanding tax-exempt bond issue with an outstanding principal amount in excess of $100,000.

It will be quite burdensome for hospitals and other nonprofit organizations to obtain this information for past bond transactions. More particularly, nonprofit organizations may have to incur substantial costs to accurately and completely fill out and answer the questions contained in Part I and Part II. For instance, Part I, Column (h) requires the organization to determine if it was an "on behalf of issuer" within the meaning of Revenue Ruling 63-20. To answer this particular question, many organizations will have to engage tax counsel and potentially obtain a legal opinion for all still outstanding bonds. Thus, VHA would recommend that this and other similar inquiries be limited to bonds issued during the year that the re-designed Form 990 is adopted by IRS and on a "going forward" basis.

Part III

Part III requests information regarding the compliance of management contracts and research agreements with the safe harbor requirements set forth in Revenue Procedure 97-13.

Answering Part III will significantly increase compliance costs. To properly answer this question, organizations will need their tax counsel to effectively issue legal opinions discussing whether the applicable safe harbor requirements contained in Rev. Proc. 97-13 were, and continue to be, satisfied.

The significant compliance costs may very well curtail certain management contract arrangements and, thus, limit an organization's ability to best fulfill its charitable mission.

Part IV

Part IV requests detailed information regarding compensation of bond transaction professionals, including whether the organization conducted a formal selection process.

This inquiry goes well beyond tax compliance and is unnecessary. There is also no tax policy or compliance reason to make this information public.

SCHEDULE L (SUPPLEMENTAL INFORMATION ON LOANS)

Parts I and II

Parts I and II require voluminous, detailed information on outstanding loans, advances, or receivables between the organization and a current or former officers, directors, trustees, key employees, highly compensated employees, and disqualified persons. Schedule L requires the following:

- *Part I inquires as to the details of each loan, advance, or receivable outstanding at the end of the organizations tax year, including*
  - *Name of debtor*
  - *Original principal amount*
  - *Balance Due*
  - *Date of loan*
  - *Maturity date*
  - *Interest rate*
  - *Security provided by debtor*
  - *Purpose of the loan*
  - *Written agreement (Yes or No)*
- *Part II inquires about information regarding loans from officers, directors, trustees, key employees, highly compensated employees, and disqualified persons*
  - *Name of creditor*
  - *Original principal amount*
  - *Balance due*
  - *Date of loan*
  - *Maturity date*
  - *Interest rate*
  - *Security provided by debtor*
  - *Purpose of loan*
  - *Written Agreement (Yes or No)*

Requiring this information will be extremely burdensome for those organizations that have a loan program under which numerous loans are made. Small rural and sole community hospitals typically have relied on loans to recruit new physicians into their service area. This practice could well be chilled by the burdensome information-gathering and disclosure required by Schedule L.

SCHEDULE M (NON-CASH CONTRIBUTIONS)

Part I

Part I requires organizations to report all non-cash contributions that are in excess of $5,000, including the donation of intellectual property.

These reporting requirements will impose significant reporting burdens on nonprofit health systems. More specifically, attempting to quantify the value of donated intellectual property, drugs, medical equipment and medical supplies will be particularly troublesome. Further, the Schedule does not mention that nonprofit organizations are not responsible for valuations, but may rely on the valuation set forth in a qualified appraisal. Since valuation of gifts is primarily the responsibility of donors, VHA does not understand why this reporting burden is now being placed on donee organizations.

SCHEDULE N (LIQUIDATION, TERMINATION, DISSOLUTION OR SIGNIFICANT DISPOSITION OF ASSETS)

Parts I and II

Parts I and II require a significant amount of reporting when organizations either cease to exist or dispose of more than 25% if their assets.

VHA views the prospect of enhanced reporting in connection with liquidations, terminations and significant asset dispositions as a favorable development. The entire schedule is consistent with relevant tax law considerations and is largely consistent with VHA's longstanding concerns about "nonprofit-to-for-profit" conversions, whole hospital joint ventures, and similar transactions. VHA believes that more transparency will tend to deter abusive practices in this area.

SCHEDULE R (RELATED ORGANIZATIONS)

Parts I – V

Schedule R requires disclosure of 16 different types of transactions (including the dollar amounts involved in these various related party transactions) with disregarded entities (e.g., single member LLCs), related tax-exempt organizations (whether exempt under Section 501(c)(3) or some other provision) related organizations that are taxable as partnerships, and related organizations taxable as corporations or trusts. Schedule R inquires about a full spectrum of transactions, including gifts, loans, capital contributions, asset sales and purchases, leases, performance of services, memberships, and fundraising solicitations.

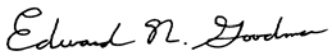
For a number of reasons, answering these inquiries will be extremely burdensome for health systems with multiple affiliates and partners. First, Schedule R requires information such as the name and address, EIN, revenue, end-of-year assets, and direct controlling entity, for all wholly-owned or controlled organizations. When attempting to identify all such related entities, the filing organization will be required to include any organization that it directly or indirectly controls. For example, when a large health care organization completes this form, it will have to include all of its subsidiaries or affiliates and all of their subsidiary organizations, and so forth. This will be an enormous task for large health care organizations.

Second, Schedule R will require reporting of a large number of plain-vanilla, everyday inter-corporate or related party transactions, such as joint fundraisers, leases of facilities, equipment or other assets, and

the sharing of mailing lists. The transaction reporting will apply to any one of 16 identified transactions including reimbursement of expenses, sharing of facilities, equipment, or employees, gifts, loans, or "other transfer of cash or property," if the aggregate amount involved for any one type of transaction during the year exceeds $5,000. Many hospitals do not currently have accounting systems in place that will allow related-party transactions to be tracked, sorted, and reported on such a basis.

VHA appreciates the opportunity to submit these comments. If you have any further questions or if we can help you in anyway to improve the new Form 990, Schedule H or any other schedules, please contact me at (202) 354-2607 or egoodman@vha.com.

Sincerely,



Edward N. Goodman
Vice President, Public Policy

cc: Catherine E. Livingston, Deputy Division Counsel/Deputy Associate Chief Counsel, EO/TE/GE, Internal Revenue Service
Kathleen M. Nilles, Partner, Holland & Knight LLP

From:	Ivy Baer
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Comment Letter from AAMC
Date:	Wednesday, September 12, 2007 9:38:49 AM
Attachments:	irs final ltr 9-12-07.pdf

I am pleased to submit the attached comment letter on selected provisions of Schedule H and Form 990 on behalf of the Association of American Medical Colleges.

Ivy Baer
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September 12, 2007

Mr. Ron Schultz
Senior Technical Advisor
Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, DC 20224

Dear Mr. Schultz:

The Association of American Medical Colleges (AAMC) is a nonprofit association representing all 126 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems; and 94 academic and scientific societies. Through these institutions and organizations, the AAMC represents 109,000 faculty members, 67,000 medical students, and 104,000 resident physicians. The AAMC welcomes the opportunity to provide the Internal Revenue Service (IRS or "the Service") with comments on proposed revisions to Form 990 (the "core form") and the new Schedule H.

The AAMC appreciates the willingness of IRS staff to meet with us and other hospital associations to discuss issues of particular concern to our members. The discussions provided a useful exchange of information. We hope that the final Form 990 and associated schedules will reflect these discussions and the written comments about the many changes that should be made before the IRS finalizes these new requirements.

Transition Period

In June 2006 the Advisory Committee on Tax Exempt and Government Entities (ACT) issued a Report of Recommendations related to Form 990. Among the recommendations were the following:

- Form 990 should be designed primarily to assess whether the filer is complying with federal tax requirements
- Form 990 and its instructions should be as understandable to a person unschooled in the law of tax-exempt organizations as possible without compromising its primary purpose

The current IRS effort does not fully reflect these recommendations. On both draft Form 990 and Schedule H the Service poses questions that go well beyond any current federal

tax requirements. Completion of the forms will require a high level of specialized knowledge, significant financial resources and staff time, and will likely prove to be extremely burdensome, especially in the initial years. The AAMC suggests that revisions of the magnitude proposed would benefit from a process that embraces the goals of the ACT report and may require more time to finalize than has been suggested by the Service.

The AAMC believes that the substantial changes needed to the draft Form 990 will necessitate a longer transition period than what has been proposed. Given that under the proposed implementation schedule the forms will not be final until later this year, and instructions are not expected to be issued until the middle of next year, it is unrealistic to expect hospitals to be prepared to file these new forms, particularly Schedule H, for the 2008 tax year. Far more reasonable would be to not require that Schedule H be used until the 2010 tax year. This would allow for a more reasonable transition period for hospitals. Those not familiar with reporting community benefit will then have ample time to prepare with full knowledge of the IRS requirements. Even those hospitals that have been reporting community benefit will need to make modifications in their systems to comply with IRS requirements and would benefit from this additional time. As the ACT recommendations suggest, the goal should be to adopt a comprehensible, uniform system for entities to accurately report information that directly relates to their tax status. Giving hospitals and other entities that complete the Form 990 and Schedule H adequate time to adapt to numerous new requirements will enhance the process and help achieve this goal.

Comments on Schedule H

The AAMC endorses the comments submitted by the American Hospital Association. We also endorse the Catholic Health Association's comments about the importance of recognizing that community building is a community benefit and should be a separate category under the Community Benefit Report.

After providing some background regarding the characteristics and activities of teaching hospitals, the AAMC's comments focus on 4 areas:

- Education
- Research
- Allowing hospitals that are closely affiliated with other organizations with separate employer identification numbers (EINs) to be viewed as a whole for the purpose of understanding the extent of the organization's total community benefit commitment.
- Recognizing that some portion of bad debt should be classified as community benefit

I. What Are Teaching Hospitals and Which of Their Activities Support Their Tax Exempt Purposes?

The AAMC is pleased that the IRS continues to recognize the essential contributions made by teaching hospitals by providing space on the proposed Schedule H Community Benefit Report for health professions education (line 6) and research (line 8).

When Rev. Rul. 69-545 was issued nearly 40 years ago, the IRS recognized that "[b]y using its surplus funds to improve the quality of patient care, expand its facilities, and advance its medical training, education, and research programs . . . . [a hospital] is operating in furtherance of its exempt purpose." While the 21st century teaching hospital has changed in many ways from its progenitors, the commitments to education, research, and patient care remain just as strong and continue to reaffirm that it merits its tax exempt status.

There is no uniformly recognized definition of a teaching hospital, though at a minimum a teaching hospital participates in the education of interns and residents. AAMC member teaching hospitals do far more than that. While accounting for 6% of all hospitals and 22% of all inpatient admissions, they provide 43% of all hospital charity care. In 2005, the latest year for which data are available, the median charity care costs for an AAMC member hospital was $8.89 million (not including bad debt). Charity care represents only a fraction of the total community benefit that teaching hospitals provide. Teaching hospitals serve local, regional, and in many cases national populations. Through education, research, patient care, and community building, a teaching hospital provides community benefits that extend well beyond the geographic area where most of its patients reside.

II. Education as a Community Benefit

Non-profit teaching hospitals are the backbone of the graduate medical education system. In FY2004, the latest year for which complete data are available, non-government, non-profit teaching hospitals trained nearly 80% of all medical residents; government hospitals (such as the VA) trained nearly 17%; and investor owned, for-profit hospitals which comprise 10 percent of all teaching hospitals, trained the remaining 3 percent[1].

Educating medical students; physicians during residency and fellowship; nurses and other health care professionals requires teaching hospitals to make a large commitment of financial resources and personnel. After graduating from medical school, future physicians enroll in a residency program that typically is sponsored by a teaching hospital. These physicians generally do not pay tuition when they enroll in a residency program, but instead receive a stipend to support them during this educational period.

Medicare---and in some states Medicaid programs—provides the only uniform explicit support to non-governmental hospitals for resident education costs through

[1] Most of these teaching hospitals were established as tax-exempt entities, but were acquired by for-profit hospital firms within the past several decades.

reimbursements that are provided only to teaching hospitals. The Medicare payment received by teaching hospitals to support graduate medical education is based on historic costs from 1983-4 that have been updated for inflation. Medicare does not pay this amount but rather only its "share" based on the percentage of Medicare patients treated in the hospital. Over the years Congress has made changes in the payment formula for direct graduate medical education, but it has never been modified to reflect actual graduate medical education costs. Medicaid support for GME is subject to each state's varied policies and the needs of the population in relation to budgetary constraints. Consequently, the reimbursement teaching hospitals receive falls short of the actual costs teaching hospitals incur to train the next generation of physicians. For this reason, health professions education can be among the largest community benefit expenditures for teaching hospitals.

No physician can obtain a state license to practice medicine without having completed at least one year in a residency program. Most hospitals require a physician to be board certified before gaining privileges, meaning that the residency program must be completed (at least three years) and an examination in the physician's specialty must be passed.

Residency programs require teaching hospitals to organize and support an array of resources. Among the requirements for educating a resident physician are supervising (or teaching) physicians, larger patient and operating rooms to accommodate trainees, and the ordering of more laboratory and other tests as young physicians learn how to practice medicine. Supporting an educational program also requires a hospital to have access to a sufficient number of patients for the residents. Additionally, conducting residency training programs requires GME administrative support to prepare and oversee resident rotation schedules and other required educational activities of the resident that extend beyond direct patient care. The educational experience for each medical specialty are established and monitored under the umbrella of the Accreditation Council of Graduate Medical Education (ACGME), the accrediting body that is recognized by the Medicare program.[2]

Educating physicians is of vital importance to the entire country. By analyzing trends in the physician workforce (e.g., the number of retirements and new graduates) and carefully assessing future needs, the AAMC has demonstrated that in some specialties and some geographic areas, physician shortages currently exist; for physicians in general, future shortages are projected. In response, the Association has called for a 30 percent increase in medical school enrollees by 2015. To ensure that all U.S. medical school graduates receive residency training, it is vital that teaching hospitals be able to continue, and in some cases increase, their commitment to educating residents to accommodate larger numbers of graduates.

[2] Osteopathic residency programs are accredited by the American Osteopathic Association which also is recognized by the Medicare program.

A. Education Worksheet

Included at the end of this comment letter is a revised worksheet, renamed "Net Costs Associated with Health Professions Education." While many of these revisions are self-explanatory; others are not and will be discussed below.

1. Indirect Medical Education (IME) Is Patient Care Revenue, Not Educational Funding

The Medicare Indirect Medical Education (IME) payment carries a "medical education" label, but its purpose, as stated by Congress when it created the prospective payment system (PPS) in 1983, is much broader:

> This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Rept, No. 98-25, March 4, 1983 and Senate Finance Committee Rept, No. 98-23, March 11, 1983).

Medicare provides the IME payment as an adjustment to the per case payment each time a Medicare beneficiary is discharged from a teaching hospital. Therefore, our members appropriately consider the IME to be a patient care payment. We believe it is more logical for teaching hospitals to include their IME payments as part of their Medicare revenue rather than as revenue associated with education. The revised education worksheet eliminates all references to Indirect Medical Education. Although the original worksheets developed by the CHA and subsequently proposed by the IRS include IME on the education worksheet, the updated worksheets that will be submitted by CHA are in agreement with the AAMC's recommendation.

2. Nursing Should Be Mentioned Separately From Other Allied Health Professions

We have suggested that, consistent with the Medicare terminology, nursing should be mentioned separately from other allied health professions.

3. All A&G Should Be Included As Costs

We also believe that it is important that all costs include related Administrative and General costs as they are necessary support for the educational programs. These costs are allowable by the Medicare program as direct graduate medical education.

4. Medicaid Direct GME Should Be Counted As A Source of Education Funding, Not As Medicaid Revenue; Indirect Should be Counted as Patient Care

Finally we suggest that Medicaid GME payments, when available, be counted as a funding source for education. For those states that make allotments for GME, the money is analogous to that provided by the Medicare program and should be counted in the same way. Therefore, it should not be counted as Medicaid revenue elsewhere on either Schedule H or Form 990 (Part IV, line 2a). Similarly, if Medicaid programs provide for IME, then those dollars should be counted as Medicaid patient care revenue, as was suggested for Medicare IME.

III. Research as a Community Benefit

Just as teaching institutions are committed to education, they also are committed to supporting research as one of their core missions. There are many different types of research that occur within an academic medical center, some within the four walls of the teaching hospital, others elsewhere such as at a related medical school or in the local community with financial support from the hospital.

Examples of various types of research are research that: involves patient care ("clinical research"); occurs in a laboratory ("bench research"); involves data analysis that looks at disease or other trends in given populations (epidemiologic research); or focuses on how to best implement new treatments or tests to make them most effective in improving health, and restructuring of health care delivery (health services research). Many residency programs require that residents engage in research, and research funds help teaching hospitals build a high-quality health sciences faculty, many of whom supervise resident training in the teaching hospital. The hospital or its affiliated organizations must have the ability to support this residency requirement.

There are multiple sources of research funding. Some clinical research that occurs in hospitals is sponsored by for-profit pharmaceutical or medical device companies while other research is funded by grants from federal agencies such as the National Institutes of Health and the National Science Foundation; and grants and contracts from nonprofit entities, such as the Howard Hughes Medical Institute. Teaching hospitals themselves devote resources to research, and thus incur net costs that are counted as community benefit.

Most research that is funded by nonprofit or governmental entities is conducted at a financial loss to the teaching hospital, as the government considers these grants or contracts to be assistance mechanisms and the awards for the research do not cover the full costs. Nonetheless, the research mission compels teaching hospitals and their affiliated organizations to support research.

In contrast, research that is sponsored by for-profit companies involves a negotiation of terms, including payment for the research so it is anticipated that an institution generally will not incur a loss for this type of research.

Research benefits the health and well being of our citizens by producing knowledge that leads to improvements in diagnosis, treatment and prevention of disease, or that may result in improvements in the health care delivery system. The benefits from research may be localized, such as a study that identifies high rates of asthma among children in a nearby community, or they may extend beyond the United States to provide a new cure for a disease that is prevalent both in this country and elsewhere.

A. Research Worksheet

Included with this letter are recommended revisions to Worksheet 7, that we propose be renamed "Net Costs of Research." We are proposing that the research that should count as community benefit be limited to research that is funded by a grant or contract from a governmental or nonprofit entity or self-funded by the institution. When research is funded by a for-profit entity, the process entails a negotiation between the two parties, and should result in a contract that covers the costs of that research. Grants and funding from nonprofit entities are never intended to cover the full costs of the research so are expected to result in a loss to the institution. They also provide ample evidence that research is a community benefit.

The AAMC also suggests that research be defined as follows:

> Any effort of which the goal is to generate generalizable knowledge, such as about underlying biological mechanisms of health and disease, natural processes or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols; laboratory based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations (including publication in a medical journal).

IV. Bad Debt As Community Benefit

As currently drafted, the IRS worksheets do not allow hospitals to count any of their bad debt as community benefit. This fails to recognize the reality that for many hospitals some portion of bad debt is, in fact, charity care and should be counted as such when quantifying community benefit.

It is not uncommon for individuals to come to emergency departments with no insurance, or with health savings accounts or high deductible policies that require large out-of-pocket expenses that they cannot afford. It also is not uncommon for these individuals, some of whom may be in this country illegally, to provide incorrect or incomplete

information to the hospital at the time the service is rendered, meaning that it is not until some point in the future—perhaps even into the next tax reporting year—that it is clear that this individual is uninsured or underinsured and could have qualified for charity care. Hospitals do not have the option of refusing to screen an individual who comes to the emergency department or, except in very limited circumstances prescribed by law, failing to treat an emergency condition.

HFMA's Statement 15, *Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers* is considered by some to be the solution to the bad debt problem. They contend that hospitals merely need to adopt a more accurate and flexible system to determine if a patient should be classified under "charity care" or "bad debt." Unfortunately, this view fails to recognize that accomplishing this goal is an extremely complex undertaking. While the IRS may want to encourage hospitals to revise their policies and comply with Statement 15, the Service should acknowledge that it will take considerable time and effort to do so and that there may be other reasonable methodologies that should be considered. As with other requirements, a change of this magnitude would necessitate a transition period. In the interim, one possibility is for the IRS to allow hospitals to report their total bad debt and then to use a proxy to estimate the portion of that amount that should be classified as charity care. To allow no portion of bad debt to be counted as charity care is to unreasonably and arbitrarily penalize hospitals for the services that they are providing for no payment or, in the case of large deductibles and co-payments, incomplete payment.

The AAMC and our member hospitals would welcome the opportunity to work with the IRS to develop a methodology that allows hospitals to more precisely classify patients and, during a transition period, to determine the portion of bad debt that should be counted as charity care.

V. Need For Some Hospitals and Other Affiliated Entities to Aggregate Their Community Benefit Activities

It is not unusual for a teaching hospital—and even for some non-teaching hospitals—to have related entities, such as a foundation or medical school, each of which has its own EIN, and each of which works in combination to provide community benefit. Academic Medical Centers have adopted different organizational structures, and the tax code played a minor or inconsequential role in how these structures have evolved. For example, one academic medical center operates a medical school and a teaching hospital together under one EIN. Another has one EIN for the medical school and another for the teaching hospital. Some academic medical centers have established separately incorporated divisions to house education activities; others operate the programs within departments of the teaching hospital. Academic medical centers thus represent a collection of entities working together to carry out a mission to which each is committed, and that cannot be accomplished without this joint effort.

For certain teaching hospitals, it is important that the IRS consider the hospital's community benefit in the context of the all of the entities with which it is affiliated and

that work as a whole to provide community benefits through patient care, education, research, and community building. As currently drafted, Schedule H only allows the hospital to report on its own activities, and not those of its affiliated partners. The AAMC strongly urges that, at a minimum, the IRS allow hospitals to provide the EINs of all other organizations that it considers to be partners in its community benefits activities, and further, to consider the extent of the hospital's community benefit contributions in the full context of the other organizations with which it is affiliated. Another possibility is for the IRS to allow use of a system analogous to that of taxable corporate filers in which the parent of a consolidated group files a tax return based on the consolidated financials of the parent and its controlled subsidiaries, all prepared in accordance with GAAP.

Comments on the Core Form (Form 990)

Although the AAMC recognizes that Form 990 would benefit from extensive changes, we have selected only a few items for comment.

I. Who Should Complete Schedule H?

Form 990 opens the door to the completion of Schedule H. The IRS has proposed that a determination about which entities should complete that schedule depends on whether an organization "operates, or maintains a facility to provide hospital or medical care." The answer to that question lies in the definition of "medical or hospital care" found in the Glossary. The AAMC urges the IRS to revise both the question and the definition to ensure that Schedule H is completed only by those entities that consider themselves to be hospitals, are looked at by their communities as hospitals, and are licensed as such by their states.

The definition proposed by the IRS casts too broad a net and would require many health care organizations not commonly considered to be hospitals to complete the Schedule. The AAMC suggests that the IRS adopt the definition of a hospital below. The examples of what is and is not a hospital should be considered illustrative only and are not meant to be an exhaustive list.

> A hospital is a health care organization that has a governing body, an organized medical staff and professional staff, and inpatient facilities and provides medical, nursing, and related services for ill and injured patients 24 hours per day, seven day per week. A hospital is a facility (and all of its components) that is licensed or recognized in its state as a hospital.
> Some examples of hospitals are:
> - General hospital
> - Rehabilitation hospital
> - Acute long term care hospital
> - Children's hospital
> - Psychiatric hospital
> - Hospital for treating certain disease categories

Some examples of facilities that are not hospitals are:

- A nursing facility (including a skilled nursing facility, convalescent home, or home for the aged)
- Free-standing outpatient clinic
- Community mental health or drug treatment center
- Physician group practices/faculty practice plans
- Physician offices
- Facility for mentally retarded/developmentally disabled
- Facility for treating alcohol and drug abuse
- Hospital wing of a school, prison, or convent

Adopting this definition will require a revision to Part VII, Question 9. We suggest that the question be changed to: Does the organization operate a hospital? If yes, complete Schedule H.

II. Executive Compensation (Core Form, Part II)

Parallel with the fact that many teaching hospitals should have their community benefit activities considered together with those entities with which they are affiliated, so too should executive compensation be considered in its totality. It is not unusual for the CEO and other key employees of a teaching hospital to receive a paycheck from multiple organizations (for example, the hospital and a foundation) and to divide his or her time among them. When entities with separate EINs share a CEO and other key employees, they must be allowed to report together regarding salary from each organization, the title given to the individual by each organization, and the percentage of time the individual devotes to each. This will provide a complete picture of salary and responsibilities, which is far more constructive information than if each entity reports on a separate schedule. The AAMC urges the IRS to adopt as an option the use of a consolidated compensation schedule for affiliated organizations with shared officers, directors, trustees, and key employees.

III. Statements Regarding Governance, Management, and Financial Reporting (Core Form, Part III)

This section asks if an organization has a written conflicts of interest policy and the number of transactions reviewed (lines 3a and b); a written whistleblower policy (line 4); and a written document retention and destruction policy (line 5). In the accompanying instructions, the following tip is provided:

> Sarbanes-Oxley requires certain tax-exempt organizations to adopt whistleblower protection and document retention and destruction policies.

This is not a requirement of Sarbanes-Oxley so this tip should be deleted.

Of concern to the AAMC is that the questions about conflicts of interest policies, whistleblowers, and document retention and destruction are unrelated to tax status. The AAMC recognizes the importance of conflicts of interest (COI) policies in a health care setting and has been a leader in developing guidelines to aid members in drafting and implementing such policies. Nonetheless, the Association questions the utility of including these policies in this context. Also, it is unclear what information is revealed by the number of transactions reviewed under a COI (Line 3b). Does a large number mean that the policy is working well since many COIs are being reviewed? Does a small number mean that the policy is ineffective in identifying possible COIs; or that few COIs exist? If the IRS decides that it will collect information on COIs, it may be more useful to ask: does the entity have in place a policy for identifying and managing conflicts of interest?

A typical AAMC member has a robust compliance program that includes a whistleblower policy, and many members also have document destruction and retention policies that reflect state law and other requirements. Despite the existence of the three types of policies singled out in this section of the Core Form, the AAMC urges the IRS to delete these questions. It is important that Form 990 be limited to collecting information that relates directly to an organization's tax status.

IV. Reporting Program Service Revenue (Core Form, Part IV, lines 2a-g)

Line 2a aggregates Medicare and Medicaid payments. The AAMC strongly urges the IRS to allow Medicare and Medicaid revenues be reported on separate lines. The programs are intended to cover very different populations and the payment rates for each are structured very differently. Hospitals should have the opportunity to clearly demonstrate the extent to which each of these Federal programs provides revenue or is operated at a loss.

We also would appreciate a clarification about whether "fees and contracts from government agencies" (line 2b) includes TRICARE and other government payers.

Conclusion

The AAMC appreciates the effort that the IRS has undertaken to revise Form 990 (the "core form") and to develop Schedule H to allow hospitals to report on their community benefit activities. In meetings, staff from the Service have reiterated their commitment to finalizing the Core Form and accompanying schedules by the end of the year. While we realize that the Service would like to obtain the information from the new and revised forms as quickly as possible, we urge you to consider the benefits of taking adequate time to ensure that the forms collect uniform information that is directly related to tax-exempt status, readily comparable across entities, and provides adequate opportunities for entities to submit a complete picture of their structures and activities. Finally, the Association asks that the IRS provide sufficient lead time to allow entities to understand how to best meet the new IRS requirements.

If you have any questions or would like additional information, please feel free to contact me, or Ivy Baer from my staff. We both may be reached at 202-828-0490 or rdickler@aamc.org and ibaer@aamc.org.

Sincerely,

Robert M. Dickler
Senior Vice President
Division of Health Care Affairs

Cc: Theresa Pattara

Attachments (2):
Net Costs of Education Worksheet
Net Costs of Research Worksheet

Net Costs Associated with Health Professions Education

1. Direct costs
    a. Medical students
    b. Interns, Residents, and Fellows
    c. Nursing
    d. Other allied health professions
    e. Continuing health professions education if open to all in community
2. **Total direct education costs** (add lines 1a-e)

Funding sources:

3. Direct medical education funding
    a. Direct Medicare reimbursement for graduate medical education
    b. Direct Medicaid GME
    c. Continuing health professions education reimbursement/tuition fees
    d. Other explicit support of education programs
4. **Total direct education revenue** (lines 3a-d)

Net costs of health education (line 2 minus line 4)

Instructions

For all direct costs include related Administrative and General. If the hospital supports the medical school library, those costs are included in the hospital's A&G. Include the following as Direct Costs (Line 1):

1. Stipends, fringe benefits of interns and residents; salaries and fringe benefits of faculty directly related to intern and resident education

2. Salaries and fringe benefits of faculty directly related to teaching of medical students (while at the hospital, or at all times?) Related overhead?

3. Salaries, fringe benefits of research trainees (PhD students, post doctoral students, MD-PhD students, others?); salaries and fringe benefits of faculty directly related to education of research trainees

4. Salaries and fringe benefits of faculty directly related to teaching of students enrolled in degree-granting nursing programs.

5. Salaries and fringe benefits of faculty directly related to teaching of students enrolled in degree-granting and/or certificate allied health professions education programs, including, but not limited to pharmacy, occupational therapy, laboratory

6. For continuing health professions education open to all in the community count salaries and fringe benefits of faculty for teaching continuing health professions education, including

payment for development of on-line or other computer-based training that is accepted as continuing health professions education by the relevant professional organization

Count as Funding Sources:

Other explicit support of education programs: examples would include grants from any source

Net Costs of Research

Note: Neither expenses nor revenues from for-profit companies for clinical trials are included

1. Costs of research that are funded by a governmental entity or a non-profit entity[3]:

    a. Direct expense
    b. Indirect expense

2. Total research costs (add a. and b.)

3. Funding sources:

    a. Grant or contract dollars received from a governmental entity or a non-profit entity source in offsetting revenue

4. **Add total funding of research costs**

5. Net costs of research (line 2 minus line 4)

Instructions

1. Define "research" to include any effort of which the goal is to generate generalizable knowledge, such as about underlying biological mechanisms of health and disease, natural processes or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols; laboratory based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations (including publication in a medical journal).

2. Examples of costs of research (Line 1) include, but are not limited to: Salaries of researchers and staff (including stipends for research trainees—either Ph.D. candidates or fellows); Facilities (including research, data, and sample collection and storage; animal facilities); Equipment; Supplies; Tests conducted for research rather than patient care; Statistical and computer support; Compliance (e.g., accreditation for human subjects protection; biosafety; HIPAA); Dissemination of research results

[3] Examples of these costs include, but are not limited to: Salaries of researchers and staff (including stipends for research trainees—either Ph.D. candidates or fellows); Facilities (including research, data, and sample collection and storage; animal facilities); Equipment; Supplies; Tests conducted for research rather than patient care; Statistical and computer support; Compliance (e.g., accreditation for human subjects protection; biosafety; HIPAA); Dissemination of research results

From:	Brown, Deborah
To:	*TE/GE-EO-F990-Revision;
CC:	Brown, Deborah; Wynn, Elisabeth;
Subject:	Greater New York Hospital Association: 990 comments
Date:	Tuesday, September 11, 2007 5:56:52 PM
Attachments:	GNYHA990CoverLtrSept07Final.pdf GNYHA990CommentsSept07.pdf

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Attached, please find Greater New York Hospital Association's comments on the proposed Form 990 and associated Schedules, as well as a cover letter summarizing our remarks. We appreciate the opportunity to provide feedback on these significant issues.

Please contact me if you have any questions or problems with this transmittal.

Thank you.

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Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

September
Twelve
2 0 0 7

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, DC 20224

Subject: GNYHA Comments on Proposed Form 990 and Schedules

On behalf of the more than 150 tax-exempt and public hospitals that make up the membership of the Greater New York Hospital Association (GNYHA), I appreciate this opportunity to comment upon the Internal Revenue Service's (IRS's) proposed redesigned Form 990 and associated Schedules.

The proposed revisions highlight many ideas that are significant to the GNYHA membership, and we will be commenting on a variety of topics addressed in the Core Form, Schedule H, Schedule I, Schedule J, Schedule K, and Schedule R. In particular, we would like to emphasize the following points:

- Despite the stated goals of the 990 project, we do not believe that the proposed forms collect the type of meaningful information that might improve transparency for the general public or promote compliance with IRS requirements. The proposed redesigned forms do, however, radically increase the burden on filing hospitals. Many large hospitals and hospital systems will need to fill out as many as 14 of the associated schedules and the majority will have to file roughly 8 to 10. This will require a significant commitment of resources for our members.

- The Core Form, particularly the first page, is seemingly designed to create a snapshot of the organization for easy public consumption and comparison. However, meaningful and appropriate differences exist among tax-exempt organizations around the country. We urge the IRS to consider a method of adjusting or segmenting responses based on organization size or other factors. Otherwise, larger, more complex urban organizations like many of our members will be viewed out of context.

- GNYHA seeks revisions to Schedule H to better reflect the requirements, or five elements, of the community benefit standard. We suggest a comprehensive reconsideration of the schedule to cleave more closely to the five elements and the

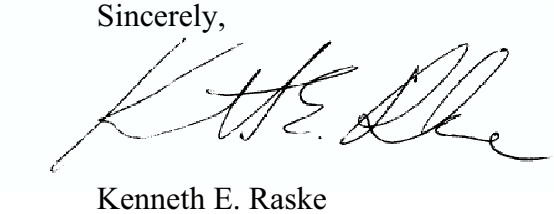
principles they represent. Indeed, we respectfully request that questions unrelated to community benefit be eliminated.

- In light of these and other concerns, we suggest that the IRS allow at least a two-year transition for implementation of the entire Form 990 and for Schedule H in particular**.** Operationally, the IRS might consider issuing a second draft of the proposed changes in 2008 with an appropriate comment and review period. Working together, the IRS and hospital community could finalize a satisfactory draft and instructions by December 31, 2008. This would give our members all of 2009 to revise their financial and data record-keeping systems so that they could accurately capture the new information that would be reported for tax year 2010.

The following letter provides a more detailed explanation of these and other reactions to the proposed forms. If you have any questions about these comments, please contact Deborah Brown (brown@gnyha.org or 212-258-5314) or Elisabeth Wynn (wynn@gnyha.org or 212-259-0719) at GNYHA.

GNYHA is grateful for this opportunity to comment on the proposed Form 990 and associated Schedules. Along with our hospital colleagues around the country, we thank the IRS staff members for their accessibility and collaborative spirit throughout this comment period. We look forward to a continued dialogue that will allow us to collectively identify and promote the many community benefits provided by tax-exempt hospitals.

Sincerely,



Kenneth E. Raske
President

GREATER NEW YORK HOSPITAL ASSOCIATION
COMMENTS ON PROPOSED FORM 990 AND ASSOCIATED SCHEDULES

September 2007

Greater New York Hospital Association (GNYHA) welcomes the opportunity to comment on the Internal Revenue Service's (IRS's) Proposed Form 990 (990) and associated Schedules. On behalf of our members, we will be identifying specific points raised in the 990 and offering our reactions, commenting on the Core Form, Schedule H, Schedule I, Schedule J, Schedule K, and Schedule R. In particular, we will be highlighting our concerns with Schedule H, particularly its focus on elements outside of the community benefit standard and the exclusion of bad debt from community benefit calculations. Overall, we believe the proposed 990 creates a significant administrative burden for tax-exempt hospitals and would respectfully request at least a two-year transition for implementation of any proposed changes.

Background on GNYHA and its commitment to community benefit

GNYHA is a trade association representing more than 250 not-for-profit hospitals and continuing care facilities, both voluntary and public, in the New York City metropolitan area and throughout New York State, as well as in New Jersey, Connecticut, and Rhode Island. GNYHA does not include or represent for-profit health care providers, so issues pertaining to tax-exemption and related reporting requirements are critical to our organization and all of its members.

GNYHA has long provided member organizations with education and support on tax-exemption and community benefit issues. In the last three years in particular, we have held regular briefings and meetings on matters including community benefit monitoring, executive compensation, conflicts of interest, and effective governance models, among other issues. We have also devoted significant resources to assisting members in their community service endeavors and in the community needs assessment and related service plans required under New York State law. In addition, we have been extremely active in developing and implementing New York State's charity care requirements, working closely with our members to promote understanding of and compliance with the law and its underlying principles. Further, GNYHA has established our Center for Trustee Initiative and Recruitment, specifically designed to promote diversity, community representation, and best governance practices in hospital boards. Our members, of course, put all of these principles into action, providing a range of meaningful community benefits and services to their neighborhoods and patients every day.

GNYHA and its members are committed to the tenets of tax-exemption and community benefit. We welcome them, and we take enormous pride in the value our member organizations bring to their respective communities through the provision of health care, education, health promotion, social services, and otherwise.

GNYHA requests a two year transition, at a minimum, before the new 990 is used.

For all of these reasons, we understand and appreciate the IRS's review of the tax-exempt sector generally and tax-exempt hospitals specifically. Like the IRS, GNYHA and its members want the tax-exempt sector to function as efficiently and purposefully as it can, and we are grateful for this opportunity to comment on revisions intended to achieve that goal. However, GNYHA has concerns about the IRS's proposed 990 and associated Schedules.

Despite the stated objectives of the 990 project, we do not believe that the proposed forms collect the type of meaningful information that might improve transparency for the general public, nor do they accurately reflect diverse organizations' operations or otherwise promote compliance. At the same time, however, these proposed changes radically increase the burden on filing hospitals, contrary to the IRS's assertions. Many large hospitals and health care systems will need to fill out as many as 14 of the associated Schedules, and the majority will have to file roughly 8 to 10. Moreover, underlying the proposed Schedule H is a dramatic philosophical shift in the legal standard imposed on tax-exempt hospitals. We have significant reservations about such a change and about various aspects of additional Schedules.

To that end, we respectfully request at least a two year transition before the new forms are implemented and ask that revised materials be made available to the public through another comment period. Our members would then have an opportunity to offer feedback on the IRS's new proposals and to prepare for requisite systems changes to meet reporting requirements. As a suggestion, the IRS could release the next revised draft with full instructions in 2008 and provide another 90-day review period, with a final form release by December 31, 2008. We look forward to a continuing dialogue with the IRS on behalf of our members, and we hope that the following ideas will be helpful in making necessary changes to the proposed forms at this point in the process.

For ease of understanding, GNYHA will identify the specific forms and lines on which it is commenting throughout this document. Any global comments will be identified as such.

CORE FORM

Broadly speaking, GNYHA is concerned that the Core Form does not allow for any distinction among organizations, regardless of considerable differences in size, budget, mission, and geographic location.

The Core Form, particularly the first page, is seemingly designed to create a snapshot of the organization for easy public consumption and comparison. However, meaningful and appropriate differences exist among tax-exempt organizations around the country. We urge the IRS to consider a method of adjusting or segmenting responses based on organization size or other factors. Otherwise, larger, more complex urban organizations like many of our members will be viewed out of context. This concern underscores several of the following specific remarks regarding the Core Form, representing our members' most significant reservations.

Part 1, Line 4, seeking the number of independent members of the governing body: **GNYHA suggests that the definition of the term "independent" be modified slightly** to exclude those who receive regular compensation or financial benefits from the organization. Under this slight change, board members who work for firms or companies that may be engaged by the organization yet who do not receive regular payment for such work would still be considered independent, and we believe this is an appropriate distinction. While we of course agree that hospitals should not be governed for any individual's personal gain, we are concerned that under the currently proposed definition, a person could theoretically lose her "independence" vis-à-vis a hospital if her law firm performed services for the hospital, even if she properly recused herself from any relevant board decision-making and did not herself receive payment from the hospital for the work. This is only an example, but similar possibilities abound. It would thus be helpful to reconsider what is meant by "independent" or merely to clarify that the type of arrangement discussed above would be acceptable.

Part 1, Lines 6, 7, 8, and other discussions of compensation, seeking the number of individuals receiving compensation in excess of $100,000, the highest compensation amount reported, and other key compensation figures: **GNYHA recommends acknowledgment of or adjustment for regional variations in reporting and evaluating compensation**. GNYHA members develop their compensation packages in a thoughtful manner, utilizing the necessary processes to determine such salaries legally and appropriately. Nonetheless, they must pay competitive salaries to attract the types of accomplished, high-quality leaders necessary to effectively run some of the most sophisticated medical centers in the world. Labor costs and executive salaries in the New York City region, which our members serve, are among the highest in the nation in all industries.

This is demonstrated by our region's Medicare wage index, the measure used to adjust Medicare payments for regional variation in wage levels. The New York City regional wade index is 1.32, while the national average is 1.00. This adjustment places us in the top ten urban areas around the country and underscores the increased labor expenses in and around New York City. Similarly, the General Services Administration, which sets the regional pay rates for Federal employees and employees, grants a 24.57% increase in the pay scale for our region. In other words, government employees, like our hospital staff members, receive increased compensation in keeping with the realities of the broader New York City area. We respectfully ask the IRS to more accurately reflect these regional differences in questions demanding compensation information. This is

particularly important as the information will be publicly available and could lead to an out-of-context perception of hospital salaries.

- **In addition, GNYHA suggests that $100,000 is too low a threshold for purposes of Line 6**. Again, hospitals in New York City must pay $100,000 salaries on something of a regular basis to attract the staff and executives we need throughout our complex organizations. As such, our hospitals will be reporting a significant number of employees who exceed the $100,000 bar. There is nothing inappropriate about that fact. Sophisticated, urban hospitals should not be unfairly compared to small organizations in rural areas, for example, that do not need to offer similar salaries. We propose that the $100,000 threshold should vary based on the size and budget of the reporting organization.

- **Further, GNYHA notes concern with the definition of "compensation."** As the IRS may know, many hospitals do not actually employ their physicians, relying on a voluntary staff model. A hospital relying on a voluntary physician model will report very different compensation statistics than its counterpart that might directly employ physicians. Neither cohort should be penalized for that distinction, but the resulting data will be meaningless and potentially harmful if misread or misunderstood. This is an ongoing problem for some hospitals, and GNYHA recommends acknowledgment of this distinction in the future.

- Part II, Section B, 3, asking whether processes for determining compensation include the elements of the rebuttal presumption: This question seems written to create a negative inference and perhaps raise flags for enforcement. **We would suggest a more direct question about the existence and elements of a process for determining executive compensation** that could yield more meaningful information.

Part II, Section B, 5, seeking information on family and business relationships among officers, directors, and others: Our hospitals report that it is quite difficult to answer these questions. **They do not have that level of insight into the family and business relationships among all of the listed individuals, and they indicate that collecting it would be excessively burdensome.** Moreover, GNYHA wonders if this additional layer of oversight is necessary. As noted below, tax-exempt hospitals already work under exacting conflict-of-interest policies. They, like the IRS are worried about potential conflicts and take steps to identify and prevent problems. Thus, we do not believe that the information sought by the IRS will yield meaningful additional data.

Moreover, our hospitals are quite conscious of the voluntary service provided by hospital trustees; GNYHA members do not financially reward their board members in any way. In fact, it is extremely difficult to get qualified board members to serve our hospital communities, and it is particularly hard to attract the next generation of younger board members. Our board members are volunteers, striving to best serve their hospitals and, in turn, their communities. Increasing the burdens placed on these volunteers would make it

more and more difficult to recruit new board members, and we wonder whether the IRS's well-intended proposal could deter volunteerism in the future.

Part III, 3b, asking how many transactions are reviewed under conflict of interest policies: **GNYHA suggests some clarification of the universe of "transactions" to be studied.** Hospitals are uncertain as to whether the IRS is inquiring about only board activities and transactions, or whether the conflicts check is to be performed on all physician activities.

Our hospitals are committed to eliminating inappropriate relationships and ensuring that clinical decisions are made for the right reasons. To that end, we spend considerable time and resources collecting and checking for conflicts through disclosure forms and other methods. However, it would be extremely difficult for the organization to review all physician activities, particularly if the physician in question is not an employee. GNYHA respectfully reminds the IRS of this difficulty.

In addition, we would suggest rephrasing the question. As currently written, this inquiry could create a negative inference in many ways. If a hospital indicates that it has reviewed no transactions, this could be seen as a problem, but if a hospital indicates it has reviewed a great number of transactions, this could be viewed negatively as well. Perhaps a better approach would be to ask whether the organization engaged in any transactions that were subject to the policy but were not reviewed, and if so, why this took place.

Part III, 10, asking whether the governing board reviewed the Form 990 before filing: **GNYHA questions the utility of requiring a full hospital board to review the IRS Form 990 and related documents.** Given the necessary size of hospital boards – not to mention the complexity of health system boards – it may be unrealistic to expect that each board member would be able to review these documents. Even if it were possible, it is questionable whether such a broad review would add much by way of targeted, constructive criticism. Requiring that the 990 and related Schedules be signed by a senior executive, accountable to the board, provides necessary assurances about the forms' contents. If additional oversight of the 990 is perceived to be necessary, we suggest that it remain vested in an appropriate subcommittee.

In addition, we would request a definition of the word "review." Without clarification, the expectation being placed on the organization is unclear, and hospital reporting is likely to vary based on interpretation.

Part III, 11, seeking information on how certain documents are made public: **GNYHA suggests a change to the wording of this question, if not removal of it.** As written, the question presupposes publication of all noted forms and could perhaps indicate impropriety if such disclosure is not regularly made. However, we respectfully note that all such documents are not required to be publicly available and suggest that some may be inappropriate for such widespread dissemination. Ultimately, we are uncertain as to why the IRS is seeking this information.

SCHEDULE H

GNYHA has two over-arching concerns about Schedule H. First, the implementation of the form should be deferred at least to tax year 2010. In addition, we believe the Schedule veers far from the fundamental elements of the community benefit standard, and we find this change troubling. On a more operational level, we are uncertain about which entities will have to complete Schedule H and respectfully request a more precise definition of "hospital" for this purpose.

GNYHA requests delayed implementation until tax year 2010.

GNYHA members are concerned about the resources required to capture and report community benefit pursuant to the proposed form. Despite years of commitment to the tenets of community benefit and a genuine dedication to its value, it will be understandably and excessively difficult for our members to master and refine the IRS's proposed community benefit measurement and reporting practices in the coming year.

The hospitals in our membership that have been working with such data collection systems attest to their inherent difficulties and nuances; they warn that it is unrealistic to believe hospitals will be able to accurately report their community benefit work within the timeline the IRS is proposing for implementation of Schedule H. Such a goal is virtually impossible for the GNYHA members – and hospitals around the country – that do not yet have practical experience working with the type of community benefit data sought by the IRS.

One hospital in our membership reports that it takes a significant investment of dedicated resources at senior levels of management and throughout each department just to do a baseline of the necessary data. Thereafter, it takes roughly one-half an FTE for populating the database on an ongoing basis, which does not include necessary finance functions. (Typically, finance departments will generate the data to be loaded on to the database, and such generation is its own considerable task.) Respectfully, the difficulty of this task is heightened by the IRS's acknowledgement that final directions and definitions will not be finalized until June 2008.

Thus, we suggest that the IRS allow at least a two-year transition for implementation of the entire Form 990 and for Schedule H in particular**.** Operationally, the IRS might consider issuing a second draft of the proposed Schedule H in 2008 with an appropriate comment and review period. Working together, the IRS and hospital community could finalize a satisfactory Schedule and instructions by December 31, 2008. This would give hospitals all of 2009 to revise their financial and data record-keeping systems so that they could accurately capture the new information that would be reported for tax year 2010.

GNYHA seeks revisions to better reflect the community benefit standard and all of its components.

Before Schedule H can be properly implemented, however, GNYHA seeks revisions to better reflect the requirements, or five elements, of the community benefit standard. GNYHA suggests a comprehensive reconsideration of the Schedule to more closely cleave to the five elements and the principles they represent. Indeed, we respectfully request that questions unrelated to community benefit be eliminated.

GNYHA emphasizes the importance of the community benefit standard.

Hospitals, like all Section 501(c)(3) charitable organizations, must operate in accordance with a tax-exempt purpose. For hospitals, this purpose is the promotion of health, with the understanding that such promotion is beneficial to the community as a whole. Since the issuance of Revenue Ruling 69-545, the IRS has applied the community benefit standard by evaluating how the five elements – an emergency room open to all regardless of ability to pay; an independent board of trustees representing the community served; an open medical staff policy; the provision of care to all persons in the community able to pay either directly or through third-party payers; and utilization of surplus funds to improve patient care, facilities, education, and similar activities – relate to the facts and circumstances of a particular hospital and the community it serves.

The community benefit standard allows hospitals to go beyond traditional health care to provide social, human, and preventative services where they are most needed. Hospitals should be commended for assuming these responsibilities, and their efforts should continue to be rightfully acknowledged as community benefits. The IRS cannot predict what a particular community needs and how a hospital can best serve those needs; such determinations should be left to an independent board of non-profit hospital trustees who live in and truly understand the community itself. As just one example, many New York City area hospitals do extensive work with their communities on proper responses in case of bio-terrorism or other similar emergency situations. These activities are meaningful to and necessary for the communities we serve and should be acknowledged as advancing our tax-exempt purpose, even though they might not be as compelling in more rural areas.

Though GNYHA hospitals are dedicated to charity care, such care is not the primary indicator of a hospital's value to its community, and it should not be the litmus test for tax-exempt status. The community benefit standard should be the test for hospital compliance, and it should be appropriately reflected in the proposed Schedule H, just as it is incorporated into other forms – most notably, Form 1023, Schedule C – and reflected in the IRS's own prior and long-standing rulings and legal precedents. A vast array of productive, community-serving institutions like schools, theatres, and museums appropriately maintain 501(c)(3) status while seeking payment for their services, because of the steps they take to uphold their tax-exempt purpose properly. Hospitals should be treated no differently.

Overall, GNYHA is troubled by what appears to be a movement towards changing the community benefit standard and the requirements for hospital tax-exemption**.** Despite current criticism, the community benefit standard has served our communities well for nearly 40 years, and it should not be dismantled.

Hospital bad debt should be recognized as a community benefit.

In addition, GNYHA believes that all existing community benefit activities should be acknowledged and requests that the IRS modify Schedule H and its instructions and worksheets accordingly. Most notably, the exclusion of bad debt from the IRS's tracking and calculation of quantifiable community benefit is a serious omission, as bad debt is truly charity care in a high percentage of cases. Hospitals provide a significant amount of care to un- or underinsured patients that is identified as bad debt only because the patients treated are unwilling or unable to complete a financial assistance application. This problem is aggravated when indigent patients require services in the emergency room, which is not a setting that is conducive to or appropriate for the completion of applications.

In New York State, for example, about two-thirds of the bad debt and charity care reported by hospitals is for outpatient care, mainly in emergency room and clinic settings. In such minute-to-minute environments serving ambulatory patients, it is very difficult to get completed applications from individuals who may be frightened of government contact for any number of reasons. Notably, the New York State Bad Debt & Charity Care Pool recognizes this and includes equal consideration of both charity care and bad debts in the methodology to distribute pool funds. We believe that this is wholly appropriate as a public policy matter.

This experience is borne out by a seminal study of income levels of bad debt and free-care patients in Massachusetts hospitals. The study finds that even in Massachusetts hospitals, which have a considerable financial incentive to correctly identify charity care patients due to the composition and operation of their State's charity care pool, nearly 80% of emergency bad-debt cases belonged to patients with incomes below the Federal poverty line.[1] The authors concluded, "both free care and bad debt can be reasonable indicators of service to indigent patients in not-for-profit hospitals" and advised policy-makers to include at least some portion of bad debt in calculations of charity care for tax-exemption requirements.[2]

The Congressional Budget Office (CBO) reached similar findings in its 2006 report, *Nonprofit Hospitals and the Provision of Community Benefits*, reviewing existing literature to state that "the great majority of bad debt was attributable to patients with incomes below 200% of the Federal poverty line." The CBO concluded that its findings "support the validity of the use of uncompensated care [bad debt and charity care] as a measure of community benefits."

[1] J.S.Weissman, P. Dryfoos, and K. London, "Income Levels of Bad-Debt and Free-Care Patients in Massachusetts Hospitals," Health Affairs, Volume 18, Number 4, July/August 1999, pg 161.
[2] Id. at 164.

GNYHA believes that the IRS should recognize the resources tax-exempt hospitals expend to provide what is truly beneficial care to their communities. We respectfully urge the inclusions of bad debt in any quantification of the community benefit standard.

Community Building activities should be included as community benefit.

In addition, GNYHA requests that the IRS reinstate reporting for Community Building activities, which would include all of the community activities undertaken by hospitals that contribute to the overall mental, physical, and social well-being of the community. Such activities are critical to the communities we serve and help to solidify the relationship between hospitals and the people who need them. As just one example, GNYHA members provide assistance to community groups to develop necessary low-income housing in the hospital's neighborhood. This service is so important to some struggling hospital neighbors, particularly those with behavioral health needs or chronic illnesses including HIV/AIDS. It would be inappropriate, we believe, to suggest that it and similar activities are insignificant as a measure of community benefit. Most importantly, the IRS should be concerned that any decision not to include this category in its analysis could discourage the provision of these community benefits by hospitals and ultimately leave the community without the many necessary services upon which it relies. We respectfully request the IRS to revisit this issue.

In addition, GNYHA raises the following specific points about Schedule H:

- Part I, seeking data on the provision of charity care, as defined by the IRS: We agree that charity care cost, losses from Medicaid, and losses from other government programs should be included in the category of charity care. As we discussed earlier, bad debts must also be considered in this section. **Furthermore, we recommend that if the IRS seeks to adopt a uniform measure of charity care, State laws or directives on the timing and data used to make charity care eligibility determinations should be explicitly recognized.** New York hospitals, for example, have worked extensively with State legislators to create certain charity care requirements and metrics, and we would respectfully suggest our State's work as a national model if one is indeed necessary.

  As of January 1, 2007, New York State hospitals are required to meet certain minimum standards with respect to the provision of financial assistance to patients who are unable to pay their bills. Compliance with these requirements is necessary for hospitals to receive critically needed funds from the State's $847 million Indigent Care Pool, which covers about 50% of documented hospital uncompensated care costs.

  Under the State law, hospitals must, at a minimum, provide emergency services to any uninsured State resident, as well as non-emergency, medically necessary services to any uninsured resident of the hospital's defined primary service area (PSA) for all patients with income levels up to 300% of the Federal poverty level (FPL). The PSA for each hospital has been defined by the New York State Department of Health. For New York City, for example, each hospital's PSA

includes all five boroughs plus Westchester county for hospitals in the Bronx, and plus Nassau County for hospitals in Queens. Therefore, each New York City hospital's PSA covers a total population of at least eight million people, a good portion of whom are uninsured. At or below 300% of the FPL, a patient's required payment is capped at the higher of what Medicare, Medicaid, or the highest volume commercial payer would have paid for the service.

New York State and its hospital partners have collectively developed a model for charity care provision that works for the intricacies of our communities. We would suggest that the IRS consider this deliberate process – and similar ones around the country – in any future charity care definition or data collection.

- Part I, Line 6, seeking information on health professions education: **GNYHA members note that the worksheet line item seeking information on "other health professionals" requires clarification**. They point out that they educate students in a range of fields and are uncertain about which of these the IRS means to include.

- Part I, Column (a), seeking information on certain community benefit activities and the number of activities or programs: **This question is not well-tailored and may yield inconsistent information.** In particular, it is difficult to quantify the reporting necessary for line 6, ("Health professions education"), line 8 ("Research"), and line 9 ("Cash and in-kind contributions to community groups."). Even with the IRS's instructions, hospitals may have difficulty sorting their programs, and there will be unanticipated inconsistencies across hospitals.

- Part I, Column (b), seeking information on the number of persons served by community benefit programs: **We suggest that this definition be changed to identify patient encounters.** It is difficult for hospitals to estimate persons served, particularly in the context of community benefit or charity care environment. Our members might see a patient in an emergency room setting, then again in a Medicaid clinic, and perhaps back again in the ER. As such, it would be nearly impossible for our hospitals to identify "individuals" served in each of the community benefit categories. In addition, it is difficult to count individuals served in something like an ongoing support group or through a health fair. As a result, we suggest that the definition be clarified such that each encounter provided to an individual is counted as a "person served."

- Part II, "Billing and Collections": **GNYHA recommends removal of this chart.** Respectfully, we believe that the proposed chart is problematic for a number of reasons. Primarily, it does not yield information that relates to the community benefit standard and, as such, does not contribute to the IRS's goal of promoting compliance with tax-exemption requirements.

  In addition, the information sought here could be competitively sensitive. Third-party payers and others would be among those that could review it, which could be harmful to hospitals in the future in ways no doubt unanticipated by the IRS.

Finally, we note that much of the underlying information sought here could be found elsewhere in the Form 990 or Schedule H. Like its counterparts around the country, GNYHA is committed to providing all appropriate information to the IRS; there is no attempt here to hide any facts. However, we would argue that the proposed billing chart itself is not the proper way to seek the necessary data.

- Part III, "Management Companies and Joint Ventures": **GNYHA suggests that the IRS merge this section into other forms or eliminate it.** Hospitals are already required to provide information on joint ventures in the Core Form and on Schedule R. As a result, these questions should be eliminated from Schedule H.

- Part IV, "General Information": **This area seems to be asking about the elements of the community benefit standard, yet this inquiry is not made clear**. Our members would suggest that such a review be more explicit and broken down into more definitive components to ensure proper and meaningful responses. This is particularly important for the question on emergency room policies, which should be reformulated to provide information consistent with the community benefit standard and with the experience gained by the IRS in asking similar questions as part of its Compliance Check Questionnaire project.

- Additional suggestions:

    - The IRS should reconfigure Schedule H to ensure that questions related to the community benefit standard and discretionary questions on non-quantifiable benefits precede the chart now labeled "Community Benefit Report."

    - The information provided by a hospital should be better contextualized. The IRS should include a section allowing filing organizations to indicate the type of facility or facilities making the report.

    - The IRS should permit live links to hospital information or attachments. For a number of questions, the space provided is not sufficient to fully describe the hospital's activities, programs, or policies. Quite often, a hospital will have preexisting documents or materials to provide this information appropriately. The IRS should permit (though not require) the insertion of live links to such information or allow attachments.

SCHEDULE I

GNYHA suggests a change to the threshold proposed in this section, particularly for hospitals and health systems. Part III of Schedule I requires an organization to report grants and other assistance to individuals in the United States if the grant amount is $5,000 or more. To require a report on every grant over $5,000 is extremely burdensome, and the resulting list would likely be too long to file electronically.

As such, we would request that this threshold be increased substantially, particularly for large organizations like hospitals. GNYHA members point out that the Federal Office of Inspector General, Office of Audit Services requires an A-133 to be filed annually with the National External Audit Review Center, employing a reporting threshold of $500,000. We would encourage adoption of this threshold.

SCHEDULE J

GNYHA members believe that Schedule J places a significant burden on respondents without a clear benefit to the IRS or the public. We respectfully question the value of some of the data sought in this section, suggesting that the IRS examine what disclosure it seeks to achieve through Schedule J.

- Question 1, Column E, seeking information on nontaxable expense reimbursements: **GNYHA members wonder why this measure is included here.** They believe this information will be very difficult to extract and question its value. Moreover, GNYHA does not believe that expense reimbursements should be reported on Schedule J, which is intended to disclose compensation amounts.

- Question 2, asking whether the respondent followed a written policy regarding payment and reimbursements: GNYHA suggests re-wording this question. **A more meaningful inquiry might be whether the respondent has such a written policy and identification of its components**. If nothing else, the question should allow for more nuance than a simple "yes" or "no" answer. Even the most vigilant institution has anomalous errors, and our members are concerned that they would be penalized for honestly reporting theirs.

- Questions 4, 5, and 6, seeking information on the basis for compensation decisions: **There is ongoing confusion about the distinctions among these points, despite attempts to clarify their different purposes.** GNYHA members suggest a more direct way of asking for this information and enhanced instructions to clarify the types of compensation arrangements that would and would not be deemed to be determined in whole or in part by the revenues or net earnings of hospitals or health care organizations. In addition, GNYHA reminds the IRS that job performance is often an appropriate component of determining compensation, within certain parameters.

SCHEDULE K

GNYHA members respectfully question the value of the information on tax-exempt bonds sought through Schedule K. The proposed form is burdensome and perhaps inefficient, and it should not be an element of the Form 990. Our members report that completion of this Schedule requires an enormous investment of labor and time, perhaps akin to a full-scale audit.

We wonder if it is appropriate to include this information on the Form 990 at all, but especially before the ongoing tax-exempt bond financing compliance check is completed. It may be more efficient for the IRS to collect the information sought in the compliance check, review it thoroughly, and then determine what type of additional oversight and disclosure processes are necessary so they can be tailored appropriately. Seeking such voluminous information at this point may not be helpful.

In addition, GNYHA has a few specific concerns:

- Part III, seeking information on private use: Question 4 of this section is difficult to answer and somewhat perplexing. It seems that the predicate for the question should be a "no" answer to Questions 2b or 3b. Requiring question 4 to be answered solely because there is a management contract or research agreement seems counterintuitive. We respectfully suggest a review of the question.

- Part IV, seeking information on compensation of third parties: This appears to be a check of post-closing activities. As each transaction is reviewed in great detail by bond counsel with the issuer at the time of the transaction, we are not yet convinced of the need for Part IV. In particular, we wonder why the issue of a formal selection process matters if hospitals are not exceeding the maximum cost of the issue.

SCHEDULE R

GNYHA members believe that the proposed Schedule R is extremely burdensome, particularly for multi-system hospitals, and suggests appropriate changes. At a minimum, the definition of "related" warrants further review and revision, as there are many possible meanings of that term.

In addition, we recommend a revision to the instructions to Part V. These instructions currently require an organization to report whether it engaged in certain transactions or transfers with related organizations, including related 501(c)(3) organizations. The instructions exempt transactions between 501(c)(3) organizations when the only transactions between the organizations are gifts or grants. We think this instruction should be revised to allow such exclusion even if the organizations participate in other transactions such as leasing or service agreements. Accordingly, we suggest that gifts or grants between 501(c)(3) organizations be excluded from the definition of "transfer" in the instructions.

Next, as Part V is currently written, it creates an enormous compliance burden for our members. We respectfully suggest that transactions between related 501(c)(3) organizations that do not result in Unrelated Business Income Tax (UBIT) need not be reported.

Finally, the expansive definition of "related" requires any exempt entity within a health care system to report all transfers between it and any other entity within the system. This requires broad and burdensome disclosure in excess of what is required under the Pension Protection Act. They result in the reporting of transactions that do not raise compliance, exemption, tax, or other concerns. We respectfully request a modification to this requirement.

Conclusion

GNYHA and its members are truly grateful for the opportunity to comment on the proposed Form 990 and its associated Schedules. Along with our hospital colleagues around the country, we thank the IRS staff members for their accessibility and collaborative spirit throughout this comment period. We look forward to a continued dialogue that will allow us to collectively identify and promote the many community benefits provided by tax-exempt hospitals.

From:	Harry A. Bold
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Emailing: IRS Form 990 Letter
Date:	Tuesday, September 11, 2007 5:56:33 PM
Attachments:	IRS Form 990 Letter.doc

<<IRS Form 990 Letter.doc>>
The message is ready to be sent with the following file or link attachments:

IRS Form 990 Letter

Note: To protect against computer viruses, e-mail programs may prevent sending or receiving certain types of file attachments. Check your e-mail security settings to determine how attachments are handled.

Big Sandy Medical Center
PO Box 530
Big Sandy, MT 59520

September 11, 2007

Internal Revenue Service
Form 990 redesign, Se: T: EO
111 Constitution Avenue, NW
Washington, D.C. 20224

RE: Comments on Draft Redesign Form 990 and Schedules

Please allow this letter to serve as notice that our Critical Access Hospital (CAH) finds the requirements of the proposed changes to Form 990 excessive and burdensome. Big Sandy Medical Center is an 8 bed CAH and has a 22 bed Skilled Nursing Home attached and we are owned and operated by a Community Board of Directors elected by the Community. All Board meetings are open to the public and each year a Public Annual Meeting is held for the community where operational and financial reports are reviewed with the public as well as the hospital's community benefit report and there is an election of several Board Members.

The proposed changes to the Form 990 would harness resources that are scarce in the business office by requiring software and staff time to compile information that would be needed on the proposed Form 990. Cost for software and staff time would be in the neighborhood of over $10,000. This past year our CAH did not even have a profit, thus the burden of these additional costs would add to either the property tax levy on the tax payers or it would result in cutting of services in other areas of the hospital. In our case and many other rural isolated hospitals such as ours, the community benefit of **access to health care is a priority!**

The community lacks quality good paying jobs, thus the reason the bad debt costs at this CAH continues to rise. Low income, uninsured and underinsured patients are the prime reasons for an ever increasing amount of bad debt each year. In our view bad debt and Medicare unpaid costs should be considered in all CAH's community benefit reports. With the ever increasing amount of Medicare Advantage patients who fall outside of the calculations of the annual cost report, Medicare unpaid charges are on the rise. Combined with other costs that Medicare does not allow, this CAH does not receive 101 percent of cost from Medicare.

The request on the proposed Form 990 requiring pricing information is not relevant. This would only allow insurers to glean this information to use against CAH's in reducing payments to bolster their bottom line.

In closing, I would strongly encourage the IRS to exempt Critical Access Hospitals from the proposed changes to the Form 990. The first and utmost benefit for communities that have a CAH is access to health care. If the burden becomes too great and the costs too excessive, the smallest and most vulnerable CAH's could be force to close. Nobody wants to see a hospital close due to federal regulations. I encourage the Internal Revenue Service to exclude CAH's from the requirements suggested in the proposed Form 990.

Please feel free to contact us if you have any questions or concerns.

Sincerely,

Harry Bold, MSA
Administrator of Big Sandy Medical Center

From:	Mike Walsh
To:	*TE/GE-EO-F990-Revision;
CC:	"Bob Olsen"; "Tony L. Pfaff";
Subject:	
Date:	Tuesday, September 11, 2007 3:43:35 PM
Attachments:	

September 11, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: COMMENTS ON DRAFT REDESIGNED FORM 990 AND SCHEDULES

I appreciate the opportunity to submit comments on the draft redesigned Form 990.

Powell County Medical Center is a 19 bed Critical Access Hospital with a 16 bed Skilled Nursing Facility operated in a combined facility model. Powell County Medical Center is a 501-c-3 operating entity for the combined operations, run by a community Board of Directors.

Powell County Medical Center provides annual community benefit reports as part of our annual BOD activities. Our community benefit reports provide the amount of detail which is practical for an organization of our size. We do not use the VHA or CHA programs because of their respective costs and lack of staff to complete the extensive data requirements. With a community centered Board of Directors transparency is really not an issue for our facility.

It is always difficult to make a “one size fits all” model as a solution especially pertaining to hospitals of varied sizes. The critical access hospital program was designed to maintain access in rural and frontier parts of the United States. Critical Access Hospitals like Powell County Medical Center struggle with cash flow and because of our environment probably are some of the most transparent hospitals in the United States. Therefore my areas of concern are identified by the following.

Probable Impacts of Proposed Form 990 on Powell County Medical Center

- The proposed reporting requirements would impose an unreasonable burden on PCMC staff and financial resources to comply at the stated level.
- Schedule H which would require PCMC to quantify the community benefits we currently discuss would cost approximately $6000 in software and a .5 FTE of staff time we do not have available. This is excessive expectation of resource use in this one area when our staff needs to be working on keeping current on CMS regulatory impacts.

To address our concerns, I concur with MHA and recommend that

- CAHs be exempted from the community benefit reporting requirement or be required to report based upon metrics currently tracked which do not require speicialized software to maintain. We use a simple Excel spreadsheet..
- The continued operation of Powell County Medical Center as a Critical Access Hospital should justify our community benefit and exempt Powell County Medical Center from the IRS proposed community benefit reporting.

I agree with the following discussion of additional concerns by MHA:

The Definition of Community Benefit should include unpaid Medicare costs and bad debt.
Providing medical treatment for the elderly and serving Medicare beneficiaries is an essential service provided by hospitals – regardless of the amount hospitals are paid for doing so.

Medicare's payments to hospitals do not cover the full cost of the care provided to Medicare beneficiaries. Nationwide, Medicare pays hospitals about 92 cents for every dollar of care they provide. MedPAC data substantiate the point that hospitals are losing money treating Medicare beneficiaries; MedPAC estimates that these losses are expected to grow in the future.

Medicare pays CAH's 101 percent of what it considers cost. However, Medicare excludes a number of costs; as a result, CAH's are really paid only 90-95 percent of cost. Unpaid Medicare costs amount to a subsidy hospitals provide to the Medicare program and are a substantial community benefit.

Much of the bad debt incurred by hospitals is for care delivered to low-income, uninsured and underinsured patients, who, for whatever reason, decline to apply for financial assistance. We serve these patients regardless of their ability to pay – which certainly qualifies as a community benefit.

In a 2006 report, the Congressional Budget Office concluded that its study supports using uncompensated care (bad debt and charity care) as a measure of community benefits.

Collecting Pricing Data
The IRS wants to collect pricing information that is not relevant to the charitable purpose of a hospital. The pricing matrix contained in Schedule H, Part II is unnecessary. Private pay pricing and discount information is proprietary. Disclosing it could give insurers a competitive advantage in negotiating contracts.

The data collected on a historical basis will serve no useful public function. The Form 990 is not an appropriate tool for the public to seek current pricing information about their health care. The Centers for Medicare and Medicaid Services is already working to post price and quality data on the Internet for common services. The effort by the IRS is redundant, at best.

Since the Form 990 is collecting historical data, the pricing information is out-of-date. Consumers need access to pricing and quality information. But that data is best obtained directly from the medical providers being considered by the consumer.

If you would like additional details or have questions please contact me.

Sincerely,

M.A. Walsh

Michael A. Walsh
Chief Executive Officer
Powell County Medical Center
(406) 846-2212, ext. 111

From:	Easterly, Mark
To:	*TE/GE-EO-F990-Revision;
CC:	Zipprich, John; Harper, Patti; Meyer, Donna; Caruthers, Sandy; ODonnell, Margaret; Bane, Ellie; Moreno, Gabriela;
Subject:	CHRISTUS Health Comments on IRS Changes to Form 990
Date:	Tuesday, September 11, 2007 3:23:21 PM
Attachments:	CHRISTUS Health Comment Ltr (09.11.07).pdf

Via Electronic Submission:

Internal Revenue Service
Form 990 Redesign
ATTN: SE:T:EO
1111 Constitution Ave., N.W.
Washington, DC 20224.

On behalf of CHRISTUS Health, please accept the attached comments to the IRS on the proposed redesigned Form 990, schedules and related instructions.

If our organization can be of any assistance, please let me know.

Mark Easterly
Regional General Counsel
CHRISTUS Health
Legal and Governance Services
713-680-4871 office
713-812-6867 fax

CHRISTUS Health Mission: To Extend the Healing Ministry of Jesus Christ

CHRISTUS Health

mark.easterly@christushealth.org
Direct Dial: (713) 680-4871

September 11, 2007

Via Electronic Filing
And Overnight Delivery

Mr. Ron Schultz
Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, DC 20224

Dear Mr. Schultz:

CHRISTUS Health appreciates the opportunity to comment on the proposed changes to the Internal Revenue Service (IRS) Form 990 and related schedules. With more than 40 hospitals, long term care facilities and senior residential communities, CHRISTUS Health is one of the ten largest Catholic health care systems in the United States. Jointly sponsored by the two religious congregations of the Sisters of Charity of the Incarnate Word in Houston and San Antonio, the Mission of CHRISTUS Health is *To Extend the Healing Ministry of Jesus Christ.*

CHRISTUS supports many of the changes proposed in the new form, not the least of which is added transparency and consistency in the reporting of charity care and community benefits. Under the leadership of our President and CEO, Dr. Tom Royer, in 2006 CHRISTUS re-emphasized a system-wide commitment to transparency with a determination to be an industry leader in making available to the public information about our health system's financial performance, community benefit, clinical quality and patient satisfaction. CHRISTUS Health supports the IRS's decision to follow the Catholic Hospital Association (CHA) framework for reporting charity care and community benefit, which has been adopted by CHRISTUS Health.

In general, our comments focus on the Form 990, the new Schedule H, and Schedule J. Specifically, we would note:

- The IRS should delay implementation of the new Schedule H. CHRISTUS Health believes the timeframe for implementing the new Schedule H is impracticable and should be extended at least to tax year 2010 as recommended by the American Hospital Association, CHA and the Texas Hospital Association. Implementation of Schedule H at a later date will allow the IRS more time to sufficiently address the

many industry concerns as expressed in commentary and response letters. The 2010 timeframe will also permit tax exempt hospitals sufficient time to modify their accounting, data collection and reporting systems as may be required by the new Schedule H.

- What organizations are required to file Schedule H? The IRS should provide further clarification as to exactly which exempt organizations are required to file the new Schedule H. For example, many tax exempt entities are member organizations within a larger nonprofit health system structured as subsidiaries under a tax exempt corporate parent organization. In particular, we would suggest that the IRS clarify that the completion of Schedule H be required only of exempt organizations that directly operate hospitals. In the alternative, Schedule H should incorporate a category to recognize a tax exempt organization that is a parent corporation within a multi-corporation health system structure. Recognizing this reality of modern health care delivery systems, a methodology for system-wide community benefit reporting, similar to the process permitted under the Texas law for nonprofit hospitals, would provide a more complete and total picture of the overall benefits provided within a particular health care system that is comprised of multiple tax exempt organizations.

- Schedule H should include community benefit questions beyond those which are purely quantitative in nature. The definitions of "cash and in-kind contributions to community groups" should be expanded to include the full range of potential contributions that a hospital might make to qualified organizations, such as the donation of hospital facilities for use by other tax exempt health care providers, equipment, supplies, or personnel donated to other exempt organizations, and health care educational programs.

- The definition of community benefit should including "community building" activities, whether or not such activities are directly related to the provision of health care. At line 10 of Part I, a new category of benefit should be added to reflect community building activities performed by exempt hospitals. These programs constitute return to the community, whether or not the activities directly relate to the provision of health care services. Examples include programs designed to improve overall community health, such as providing financial support for low-income housing, job training programs, scholarships, grants, low interest or forgiven loans to community organizations, local and regional relief from natural disasters, and other similar charitable activities.

- Part II on billing and collections should be removed from Schedule H. Part II of Schedule H relating to billing and collection practices should be eliminated, as this information does not relate in any way to an organization's qualification as a tax

exempt entity. Collecting and submitting this information to the IRS will merely increase the administrative burden on hospitals.

- Part III on management companies and joint ventures should be removed. Proposed Part II of Schedule H requires hospitals to provide information concerning any management companies or joint ventures that it is a partner or shareholder thereof, along with the names of officers, directors, trustees or key employees having ownership interests therein. As with the Part II question on billing and collection practices, this section should be removed as the activities inquired about have no relation as to whether an organization provides community benefits and qualifies as a tax exempt entity. The collection and submission of this irrelevant information will only further burden tax exempt hospitals with administrative costs.

- Medicare cost and bad debt should not be included as community benefit categories. CHRISTUS Health supports the CHA position that the unpaid cost of Medicare and bad debt should not be included in the definition of community benefit. This position is also consistent with the definitions of charity care found in the Texas state law for tax exempt hospitals, which CHRISTUS currently complies with and which our organization believes provides an accurate representation of the level of benefit a hospital returns to a community.

- Nontaxable expense reimbursements reporting on Schedule J. We suggest that the proposed requirement to report the nontaxable expense reimbursements to trustees, officers, directors, and other key employees be deleted from Schedule J. Accurately capturing and reporting this information for all individuals listed on Part III of the Form 990 would be impracticable, if not impossible. Further, in the interest of transparency and accurate disclosure, if nontaxable expense reimbursements are reported along with the other direct compensation and benefit information on Schedule J, it could lead to a distortion or misrepresentation of the complete compensation packages for executives and key employees.

To summarize, CHRISTUS Health views the draft redesigned Form 990 and Schedules as an important resource for tax exempt hospitals to share their unique stories with the communities they serve and the public at large. We support all changes that allow hospitals to clearly and uniformly demonstrate benefit activities to the public and communities we serve. We are pleased that the IRS based Schedule H on the CHA standards for reporting charity care and community benefit area. In our opinion, by considering and adopting the comments and suggestions within this letter, the IRS will produce a more understandable and reliable return form that provides users and reviewers with a more accurate portrait of the activities and benefits of tax exempt hospitals.

If our organization can be of any assistance, please let us know.

Sincerely,

Mark Easterly
Regional General Counsel
CHRISTUS Health

WME/

Cc: Donna Meyer
John Zipprich
Margaret O'Donnell
Sandy Caruthers
Patti Harper
Gabriela Moreno

From:	Bob Olsen
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Form 990 Comments
Date:	Tuesday, September 11, 2007 11:02:17 AM
Attachments:	MHA 990 Letter.doc

Please accept the attached letter providing our comments on the proposed modification of the IRS Form 990. Contact me if you have any questions, or need additional information.

Bob Olsen
Vice President
MHA An Assoc of MT Health Care Providers
406.457.8004

September 7, 2007

By Electronic Filing

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: COMMENTS ON DRAFT REDESIGNED FORM 990 AND SCHEDULES

MHA, An Association of Montana Health Care Providers, on behalf of our 63 member hospitals, health care systems, networks and other providers of care, appreciates the opportunity to submit comments on the draft redesigned Form 990.

Hospitals have numerous concerns about the proposed modifications and the significant new burdens imposed on hospitals. Our member hospitals and Association staff have worked collaboratively with the American Hospital Association to review the Form 990 and new schedules. We endorse the comments provided by AHA, and ask the IRS to incorporate the recommendations of the AHA in a final regulation.

MHA appreciates the work the IRS has put into its proposed rewrite of the Form 990. We also appreciate the IRS' willingness to discuss these proposed changes with MHA and AHA.

MHA believes it is essential that hospitals voluntarily, publicly and proactively report to their communities the full value of benefits they provide. The MHA Board of Trustees endorsed this principle in a policy statement adopted in August 2006. Since then, staff has worked with member hospitals to fulfill this commitment.

The proposed revisions to the IRS Form 990 would take transparency to a new and significantly higher level. While, we certainly welcome transparency, the IRS proposals raises a number of significant issues that we believe must be addressed before these rules are finalized. Specifically, MHA has identified the following areas of concern.

Impact on Small and Rural Hospitals

- The proposed reporting requirements would impose an unreasonable burden on hospitals, especially critical access hospitals.
- The IRS would substantially change the Form 990 and create 15 new reporting schedules for tax-exempt organizations, including hospitals. MHA staff estimates that Montana hospitals may have to complete as many as eight of these forms.

- Critical access hospitals are least able to comply with the new reporting requirements, especially Schedule H which would require them to quantify the community benefits they provide.
- CAH's have minimal staff in their billing and business offices.
- CAH's do not have staff trained to compile community benefit information, nor do they have the software needed for this task.
- MHA members estimate that compliance would require 120-160 hours a year of staff time. This does not include the time required to install and train staff on how to compile the data.
- The software used by CHA and VHA hospitals to compile community benefit data costs more than $6,000 to purchase. In addition, annual update fees are charged. Only one of Montana's 45 CAH's uses this software currently.

To address our concerns, MHA recommends that

- CAHs be exempted from the community benefit reporting requirement or be required to report based upon a significantly reduced dataset.
- The continued operation of CAHs – providing the only access to health care in frontier communities – should justify their community benefit.
- Instead of quantifying their community benefit, as proposed by the IRS, CAH's could be required to list the community benefits they provide and the direct cost for those activities. This would ensure accountability while also avoiding the extra administrative burden caused by measuring indirect costs, as required on the CHA and VHA software.

The Definition of Community Benefit should include unpaid Medicare costs and bad debt.
Providing medical treatment for the elderly and serving Medicare beneficiaries is an essential service provided by hospitals – regardless of the amount hospitals are paid for doing so.

Medicare's payments to hospitals do not cover the full cost of the care provided to Medicare beneficiaries. Nationwide, Medicare pays hospitals about 92 cents for every dollar of care they provide. MedPAC data substantiate the point that hospitals are losing money treating Medicare beneficiaries; MedPAC estimates that these losses are expected to grow in the future.

Medicare pays CAH's 101 percent of what it considers cost. However, Medicare excludes a number of costs; as a result, CAH's are really paid only 90-95 percent of cost.
Unpaid Medicare costs amount to a subsidy hospitals provide to the Medicare program and are a substantial community benefit.

Much of the bad debt incurred by hospitals is for care delivered to low-income, uninsured and underinsured patients, who, for whatever reason, decline to apply for financial assistance. We serve these patients regardless of their ability to pay – which certainly qualifies as a community benefit.

In a 2006 report, the Congressional Budget Office concluded that its study supports using uncompensated care (bad debt and charity care) as a measure of community benefits.

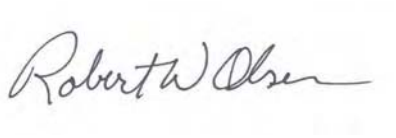
Collecting Pricing Data
The IRS wants to collect pricing information that is not relevant to the charitable purpose of a hospital. The pricing matrix contained in Schedule H, Part II is unnecessary. Private pay pricing and discount information is proprietary. Disclosing it could give insurers a competitive advantage in negotiating contracts.

The data collected on a historical basis will serve no useful public function. The Form 990 is not an appropriate tool for the public to seek current pricing information about their health care. The Centers for Medicare and Medicaid Services is already working to post price and quality data on the Internet for common services. The effort by the IRS is redundant, at best.

Since the Form 990 is collecting historical data, the pricing information is out-of-date. Consumers need access to pricing and quality information. But that data is best obtained directly from the medical providers being considered by the consumer.

We appreciate the opportunity to comment on the proposed guidelines. Please contact me or John Flink for additional information at (406) 442-1911.

Sincerely,



Robert W. Olsen
Vice President
Regulatory Affairs

From:	Ray Gibbons
To:	*TE/GE-EO-F990-Revision;
CC:	John Flink;
Subject:	Comments on form 990 proposals
Date:	Monday, September 10, 2007 2:02:45 PM
Attachments:	TMC Board Meeting - 10 06.ppt 990 letter.doc image001.jpg

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My comments are attached.

H. Ray Gibbons, FACHE

Administrator/CEO

Teton Medical Center

Voice- 406.466.6001 Fax:406.466.5842

Teton Medical Center

915 4th St. N.W.
Choteau, Montana 59422
(406) 466-5763
www.tetonmedicalcenter.net

September 10, 2007

By Electronic Filing

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: COMMENTS ON DRAFT REDESIGNED FORM 990 AND SCHEDULES

I appreciate the opportunity to submit comments on the draft redesigned Form 990.

Teton Medical Center is a 12 bed frontier Critical Access Hospital with a 34 bed Skilled Nursing Facility operated in a combined facility model. Teton Medical Center is a government entity by the status of the Teton County Hospital District however, we are in process of applying for a 501-c-3 operating entity for the combined operations. If we are successful in establishing the 501-c-3 operating entity the completion of the Form 990 becomes a reality. It is with this in mind that I make my comments.

Teton Medical Center has provided annual community benefit reports as part of our annual meeting each October. Our community benefit reports provide the amount of detail which is practical for an organization of our size. We do not use the VHA or CHA programs because of their respective costs and lack of staff to complete the extensive data requirements. As a tax supported entity with all of our Board meetings open to the public transparency is really not an issue for Teton Medical Center.

It is always difficult to make one solution “fit” all types of entities particularly hospitals. The critical access hospital program was designed to maintain access in rural and frontier parts of the United States. Critical Access Hospitals like Teton Medical Center struggle with cash flow and because of our environment probably are some of the most transparent hospitals in the United States. Therefore my areas of concern are identified by the following.

Probable Impacts of Proposed Form 990 on Teton Medical Center

- The proposed reporting requirements would impose an unreasonable burden on TMC staff and financial resources to comply at the stated level.
- Schedule H which would require TMC to quantify the community benefits we currently discuss would cost approximately $6000 in software and a .5 FTE of staff time we do not have available. This is excessive expectation of resource use in this one area when our staff needs to be working on keeping current on CMS regulatory impacts.

To address our concerns, I concur with MHA and recommend that

- CAHs be exempted from the community benefit reporting requirement or be required to report based upon metrics currently tracked which do not require speicialized software to maintain. We use a simple Excel spreadsheet..
- The continued operation of Teton Medical Center as a Critical Access Hospital should justify our community benefit and exempt Teton Medical Center from the IRS proposed community benefit reporting.

I agree with the following discussion of additional concerns by MHA:

The Definition of Community Benefit should include unpaid Medicare costs and bad debt.
Providing medical treatment for the elderly and serving Medicare beneficiaries is an essential service provided by hospitals – regardless of the amount hospitals are paid for doing so.

Medicare's payments to hospitals do not cover the full cost of the care provided to Medicare beneficiaries. Nationwide, Medicare pays hospitals about 92 cents for every dollar of care they provide. MedPAC data substantiate the point that hospitals are losing money treating Medicare beneficiaries; MedPAC estimates that these losses are expected to grow in the future.

Medicare pays CAH's 101 percent of what it considers cost. However, Medicare excludes a number of costs; as a result, CAH's are really paid only 90-95 percent of cost.
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Much of the bad debt incurred by hospitals is for care delivered to low-income, uninsured and underinsured patients, who, for whatever reason, decline to apply for financial assistance. We serve these patients regardless of their ability to pay – which certainly qualifies as a community benefit.

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Collecting Pricing Data
The IRS wants to collect pricing information that is not relevant to the charitable purpose of a hospital. The pricing matrix contained in Schedule H, Part II is unnecessary. Private pay pricing and discount information is proprietary. Disclosing it could give insurers a competitive advantage in negotiating contracts.

The data collected on a historical basis will serve no useful public function. The Form 990 is not an appropriate tool for the public to seek current pricing information about their health care. The Centers for Medicare and Medicaid Services is already working to post price and quality data on the Internet for common services. The effort by the IRS is redundant, at best.

Since the Form 990 is collecting historical data, the pricing information is out-of-date. Consumers need access to pricing and quality information. But that data is best obtained directly from the medical providers being considered by the consumer.

If you would like additional details or have questions please contact me. If you would like to see a frontier community benefit report I have attached our 2006 report to the electronic response system.

Sincerely,

H. Ray Gibbons, FACHE
Administrator/CEO
406.466.6001